

EVALUATION AND ORGANIZATIONS:
THE CASE OF COMMUNITY MENTAL HEALTH CENTERS

By

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This work analyzes the role that evaluation plays in a group of mental health organizations. It examines the hypothesis that organizations are incapable of critically evaluating their own activities due to the priority given to requirements for survival.

Formal, scientific evaluation is distinguished from less formal and more subjective types of evaluation. Three dimensions of evaluation are developed in order to distinguish "critical" evaluations from "token" evaluations: (1) the scope of the activities of the organization covered by the evaluation; (2) the focus of the evaluation--whether it is oriented towards measuring intermediate or end goals; (3) the substance of the evaluation--how much change actually results

from the introduction of the evaluation.

The research problem is seen as being related to four important areas of organizational and public administration theory: (1) the extent to which organizations are survival or goal-oriented; (2) the resistance of the "natural" system of the organization to the encroachment of formal aspects of the organization; (3) the importance of the technology of organizations; and (4) the issues of accountability and responsibility of public organizations.

The sample of organizations studied includes fourteen mental health centers and clinics in the State of Florida. The methods used include five months of participant observation in one mental health center, and interviews and questionnaires administered to clinicians, evaluators, and directors of the above organizations.

One finding is that evaluation has little impact on those organizations in which it is introduced. However, there is little evidence of overt opposition to evaluation. It is introduced in such a non-threatening way that it is not expected to play a significant role in decision making.

Organizations that voluntarily undertake formal evaluation expect it to contribute to the survival of the organization by providing a means of justifying the public funds spent to support them, by helping to secure grants, and by giving them greater influence over possible future evaluations by outsiders.

Four major factors are seen as important in determining whether an evaluator is able to achieve responsiveness to the values he wishes to emphasize: (1) the kinds of values held by the evaluators and the persons being evaluated; (2) the extent to which the evaluators are motivated to achieve responsiveness to their values; (3) the types of authority exercised by the evaluator and the reaction of the persons being evaluated to these types; and (4) the extent to which evaluators possess information to determine whether or not their evaluations had their intended effect.

Generally, there is confirmation of the thesis that critical evaluation is rare in organizations because of the tendency of activities most closely associated with organizational survival to displace other types of activities. Certain factors which increase the likelihood of critical evaluation in organizations are noted.

CHAPTER I

INTRODUCTION

The Problem

The original inspiration for this dissertation was a simple yet intriguing question raised by Aaron Wildavsky: "Can organizations evaluate themselves?"¹ Wildavsky argues that organizations and the people composing them generate such strong commitments to programs, goals, clientele, and to the adaptive needs of survival in general, that self-evaluation is impossible.² However, since evaluation would cost more than it is worth unless it leads to substantive change, evaluators within organizations need the power, stability, and additional resources that can force the other people in the organization to listen to them and accept the recommendations based on their evaluations. Yet, the very pursuit of these kinds of resources is likely to displace the evaluators from their original goals and lead them to new commitments which are very similar

¹Aaron Wildavsky, "The Self-Evaluating Organization," Public Administration Review, Vol. 32 (November/December, 1972), pp. 509-520.

²"Evaluation" will be defined below.

to those held by others in the organization. The implication of Wildavsky's analysis is that evaluation is likely to result in little substantive change, and the evaluators are likely to be either frustrated or coopted.

This study examines the role³ that evaluation has played in a group of organizations and the question raised by Wildavsky. It is an organizational study which explores the relationship between evaluative behavior in organizations and organizational elements such as formal authority, the informal system, etc.⁴ The examination of the role of evaluation in organizations can be broken down into sub-areas of research questions which are explored in this dissertation, including the following:

1. What impact has evaluation had on the group of organizations under study? What part does it play in the decision making that takes place in the organizations?
2. What are the attitudes towards evaluation of the individuals composing the organizations being studied?
3. What are the forces which lead organizations (in this study) to invest in undertaking evaluations? Why do certain organizations invest more heavily in evaluation than others?
4. What are the factors involved which are likely to make evaluators successful in achieving the goals of their evaluations?

³"Role" is being used broadly here to refer to both the actual and anticipated consequences of evaluation. These consequences include both manifest and latent functions, and functional and dysfunctional consequences.

⁴See below for a further discussion of these and other elements of organizational theory.

Community Mental Health Centers

The research for this dissertation was carried out on thirteen community mental health centers and one clinic in the State of Florida.⁵ Community mental health centers were established in the 1960's for several reasons including the goals of providing psychiatric services to those who could not afford private therapists, of putting more emphasis upon prevention of mental illness, and of reducing the large state mental hospital loads.⁶ Organizations designated as mental health centers are distinguished by the fact that they have received support from the National Institute of Mental Health (NIMH) in return for which they offer as a minimum the following services: (1) outpatient care, (2) inpatient care, (3) emergency care, (4) partial hospitalization care, (5) consultation and education programs.⁷ The area served by each mental health center is called its "catchment area." A district board composed of

⁵The thirteen community mental health centers included the entire population of centers which had already received funded staffing grants by the beginning of this study. The reason for the inclusion of the one clinic was that it was highly advanced with respect to evaluation.

⁶See Joint Commission on Mental Illness and Health, Action for Mental Health (New York: Basic Books, 1961).

⁷See Allan Beigel and Alan Levenson, "The Community Mental Health Center: Strategies and Concepts," in The Community Mental Health Center: Strategies and Programs, ed. Allan Beigel and Alan Levenson (New York: Basic Books, 1972), pp. 3-16.

members from the catchment area oversees the operations of each mental health center. The mental health centers in Florida also receive financial support from State Division of Mental Health.

Community mental health centers offer a particularly fruitful opportunity to study the role of evaluation in organizations and the above research questions because there is substantial evidence that they are among the most advanced of service organizations in implementing formal evaluation. The National Institute of Mental Health and community mental health centers have devoted more resources to evaluation than any other health agencies.⁸ In an interview concerning evaluation in the Department of Health, Education, and Welfare (HEW), the then Secretary of HEW, Elliot Richardson, cited community mental health centers as being the best example of where evaluation results had been put to use.⁹ A study carried out by NIMH found that program evaluation had become the single most important concern of mental health centers.¹⁰

In particular, the mental health centers and clinics in the State of Florida appeared to be in the forefront of the movement

⁸See Garth Buchanan and Joseph S. Wholey, "Federal Level Evaluation," Evaluation, Vol. 1, No. 1 (1972), p. 19.

⁹Susan Salasin, "Conversational Contact with Elliot Richardson," Evaluation, Vol. 1, No. 1 (1972), p. 16.

¹⁰Howard Davis, "A Solution for a Crisis?" Evaluation, Vol. 1, No. 1 (1972), p. 3.

to experiment with evaluation. Nearly all of these organizations had introduced or were planning to develop some form of formalized evaluation.¹¹ In short, it seemed that the role of evaluation was likely to be at least as highly articulated in this group of mental health organizations as in nearly any other type of public organization. Furthermore, because they were advanced with respect to evaluation, they would provide a good opportunity to examine the thesis that organizations are incapable of evaluating themselves. Glaser and Strauss have argued for what they call "theoretical sampling" which includes the deliberate search for cases which seem to be contrary to the theory or hypothesis being tested.¹²

The Literature

Not all social scientists are as pessimistic as Wildavsky concerning the utility of evaluation. Moynihan argues that the social sciences are at their worst in offering theories of how to bring about massive behavioral change and that the "correct" role of the social sciences lies not in the formulation of social policy but in the

¹¹At a meeting attended by the author, NIMH officials indicated that the mental health centers included in the group being studied here were relatively advanced with respect to evaluation in comparison with most other mental health centers.

¹²Barney Glaser and Anselm Strauss, The Discovery of Grounded Theory: Strategies for Qualitative Research (Chicago: Aldine Publishing Company, 1967), p. 56.

measurement of its results.¹³ Rivlin states that in the last decade much progress has been made concerning our knowledge of the prevalence and incidence of social problems and that we now need to concentrate more on how to produce effective programs and measure the costs and benefits of these programs.¹⁴ Allen Schick argues that evaluation is likely to be more productive than past innovations such as program budgeting and policy analysis for the following reasons: (1) the focus of evaluation is more limited and hence manageable than that of policy analysis; and (2) evaluation is retrospective and thus more compatible with the budgetary process than program budgeting and policy analysis.¹⁵ Donald Campbell also states that the role of the social scientist should be to create a public demand for hard-headed evaluations and to be committed to the solving of problems rather than to the particular means of solving them.¹⁶

Actually, even those who are generally enthusiastic about the concept of evaluation are pessimistic about the possibility of

¹³Daniel P. Moynihan, Maximum Feasible Misunderstanding (New York: Free Press, 1969), pp. 191-196.

¹⁴Alice M. Rivlin, Systematic Thinking for Social Action (Washington: Brookings Institution, 1971), pp. 7, 60.

¹⁵Allen Schick, "From Analysis to Evaluation," The Annals of the American Academy of Political and Social Science, Vol. 385 (September, 1969), pp. 61-70.

¹⁶Donald T. Campbell, "Reforms as Experiments," American Psychologist, Vol. 124 (April, 1969), pp. 409-429.

organizations evaluating themselves. Moynihan calls for an office of legislative evaluation because of the natural tendency to oversell one's programs and because of the need to ensure the honesty of the evaluators.¹⁷ Schick notes that in order for evaluation to be taken seriously it must be linked with funding.¹⁸ Rivlin agrees that there will be a great tendency to cheat in projects that are being evaluated and consequently an independent evaluation is necessary.¹⁹

Campbell points out several plausible but questionable ways in which administrators may use data to demonstrate the success of their reforms.²⁰ Edward Suchman has even created a classification of strategies for which management and administrators may use evaluation: (1) eyewash: using evaluation to justify weak or bad programs by selecting out good aspects for evaluation, (2) whitewash: using evaluations to cover up failures by avoiding any objective appraisal, (3) submarine: using evaluation to destroy a program, (4) postponement: using evaluation to delay needed action by pretending to seek or research other factors.²¹ Thus most experts

¹⁷ Moynihan, Maximum Feasible Misunderstanding, p. 200.

¹⁸ Schick, "From Analysis to Evaluation," p. 70.

¹⁹ Rivlin, Systematic Thinking for Social Action, p. 409.

²⁰ Campbell, "Reforms as Experiments," pp. 420-429.

²¹ Edward A. Suchman, "Action for What? A Critique of Evaluative Research," in Evaluating Action Programs: Readings in Social Action and Education, ed. Carol H. Weiss (Boston: Allyn and Bacon, 1972), pp. 52-84.

favor an "outsider" approach to evaluation because they, like Wildavsky, have strong doubts about whether or not public organizations can critically evaluate themselves.²²

However, there is little evidence to support the proposition that outsider evaluation is more effective than insider evaluation.²³ A recent review of on-going evaluation in the federal government concludes as follows:

Despite the increased evaluation activity that we will describe in the survey, the present evaluation picture is not impressive in terms of identifiable impact on policy decisions and program operations.²⁴

The reasons for the failure of contractual or outsider evaluation are numerous, and include anxiety, suspicion, lack of cooperation and sabotage on the part of the operating personnel, especially when the findings reveal anything negative concerning the operations of the programs.²⁵

²²See, e.g., Edward A. Suchman, Evaluative Research: Principles and Practice in Public Research (New York: Russell Sage, 1967), p. 18.

²³Even Suchman, generally a proponent of outsider evaluation, admits that insider evaluations are more likely to have an impact on the operations of the organization. See Edward Suchman, Evaluative Research, pp. 158, 163.

²⁴Garth N. Buchanan and Joseph S. Wholey, "Federal Level Evaluation," Evaluation, Vol. 1, No. 1 (1972), p. 17.

²⁵For a description of the reaction of individuals in one organization to a negative evaluation, see James A. Davis, "Great Books and Small Groups: An Informal History of a National Survey," in Sociologists at Work, ed. Phillip Hammond (New York: Basic Books, 1964), pp. 212-234.

From an organizational perspective, evaluation must become institutionalized as an integral component of the organization's decision making system which a "one shot" outsider evaluation simply cannot accomplish. Thus, three experts who review the problems of recent evaluation efforts come to similar conclusions-- that emphasis should be given to tying evaluation to the decision making system of the organization and that more "insider" evaluation should be done:

First, resources must be shifted from contract work to in-house evaluation design efforts. In the past, federal agency evaluation offices have relied solely on contractors for design work, partly because the cost of an in-house technical staff was considered too high. But it is our view that the price of this practice in unsatisfactory evaluation is higher, really, than the cost of having the design function carried out by in-house staff.²⁶

It seems that, despite reservations of nearly everyone, more insider or internal organizational evaluation will be done by public organizations, which makes the problem being addressed here timely: "What role does insider or self-evaluation play in organizations?"²⁷

²⁶Garth Buchanan, Pamela Horst, and John Scanlon, "Improving Federal Evaluation Planning," Evaluation, Vol. 1, No. 2 (1973), p. 90.

²⁷However, comparisons will be made with external forms of evaluation when such comparisons aid in the analysis of the role of internal evaluation.

Concepts

This work explores the relationship between two basic concepts: evaluation and organization. Originally, the following definition of evaluation was developed: "evaluation is the formal process of measuring the attainment of goals, however defined, through the employment of the tools of science."²⁸ The author had hoped to delimit the field of study by avoiding less formal and scientific forms of evaluation such as the "gut-feeling" or highly subjective forms of judgments which take place in nearly all forms of human interaction.²⁹ However, while the original definition of evaluation was retained, it became apparent that the relationship between these more traditional forms of subjective evaluation and the formal, scientific evaluations is an issue of major importance in attempting to analyze the role that evaluation plays in these organizations.

Likewise, the question of whether or not there exists a truly "scientific" evaluation technology that is capable of measuring the goals of mental health centers became problematical. All current evaluations (both formal and informal) rely to a significant extent on subjective judgments and are anchored in particular value systems.

²⁸For a review of definitions of evaluation, see Francis G. Caro, "Approaches to Evaluative Research: A Review," Human Organization, Vol. 28 (Summer, 1969), pp. 87-99.

²⁹Indeed, at least one major form of therapy has as one of its basic techniques the avoidance of the universal tendency to make evaluative judgments. See Carl R. Rogers, Client-Centered Therapy (Boston: Houghton Mifflin, 1951).

Yet, there still remains a difference between what the author has called "formal, scientific evaluation" and purely subjective evaluation: the former is public and amenable to retesting by people other than the original evaluator while the latter type of judgment is the "property" of the evaluator.³⁰

Thus the above definition of evaluation serves to distinguish between those centers that are carrying out formal scientific evaluations and those which are not. However, in order to more precisely examine the role that evaluation plays in these organizations, the following three dimensions were developed. Among other things, they help to distinguish between truly critical evaluations and merely token evaluations:

<u>Token Evaluation</u>	<u>Critical Evaluation</u>
Scope: Narrow	Broad
Focus: Technique-Oriented ³¹	Accomplishment-Oriented
Impact: Symbolic ³²	Substantive

³⁰As is often the case when one attempts to make a distinction between two categories, there are some examples that do not fit into either category. Such cases will be noted in the discussion concerning specific evaluative techniques in Chapter II.

³¹For the distinction between evaluations which focus on techniques and those which focus on more accomplishment-oriented goals, see Brian MacMahon, Thomas Pugh, and George Hutchison, "Principles in the Evaluation of Community Mental Health Programs," American Journal of Public Health, Vol. 51 (July, 1961), pp. 964-968.

³²For a discussion of the differences between "symbolic" and "substantive" evaluative research, see Joseph Eaton, "Symbolic and Substantive Evaluative Research," in Program Evaluation in the Health Fields, ed. Herbert C. Schulberg, Alan Sheldon, and Frank Baker (New York: Behavioral Publications, 1969), pp. 506-524.

Community mental health centers may undertake evaluations that conform for a variety of reasons (to be explored later) to the definition of formal, scientific evaluation but may not achieve or even attempt to achieve any real change. When Wildavsky argues that an organization cannot evaluate itself, he is probably saying that whatever formal evaluation it undertakes is likely to be narrow in scope, technique-oriented, and unlikely to achieve any substantive change. These three dimensions will be employed as guidelines in our analysis of the methods of formal evaluation.³³

The concept of organization is even more difficult to define and use systematically than evaluation.³⁴ An organization is viewed here as an open system consisting of the interaction of its components including the formal organizational structure and the informal relationships developed by organizational members.³⁵ Behavior

³³These three dimensions will be used as general guidelines in our analysis of each technique. No attempt was made to construct quantitative indices of any of these dimensions. For a discussion of the utility of employing such qualitative guidelines, see Anselm Strauss, et al., Psychiatric Ideologies and Institutions (New York: Free Press, 1964), pp. 31-35.

³⁴A review by Ralph Stodgill found some eighteen different major orientations to the concept of organization. See his "Dimensions of Organizational Theory," in Approaches to Organizational Design, ed. James D. Thompson (Pittsburgh: University of Pittsburgh Press, 1963), pp. 1-56.

³⁵For the classic analysis of the distinction between these two elements of an organization, see Alvin W. Gouldner, "Organizational Analysis," in Sociology Today: Problems and Prospects, ed. Robert K. Merton, et al (New York: Basic Books, 1959), pp. 400-428.

within organizations is also shaped by factors such as the technology employed by organizational members in the accomplishment of their tasks, the personalities of organizational members, and the values which organizational members hold.³⁶ Nearly all organizations are strongly influenced by their environments. Important elements of the environments of these community mental health centers included the following: (1) the clientele of the organizations, (2) the suppliers of the organization, including the funding agencies and private foundations, (3) competitors of the organizations which include both other governmental agencies competing for funds and also private practitioners insofar as they overlap with the centers in serving the same clientele, (4) regulatory groups which include not only the funding agencies but also the district mental health boards which oversee the operations of the mental health centers.³⁷

³⁶For organizational studies which tend to emphasize organizational structure, technology, and interpersonal relationships respectively, see Peter M. Blau and Richard Schoenherr, The Structure of Organizations (New York: Basic Books, 1971); Charles Perrow, Complex Organizations: A Critical Essay (Glenview: Scott, Foresman, and Company, 1972); and Chris Argyris, Integrating the Individual and the Organization (New York: John Wiley and Sons, 1964).

³⁷This discussion of the elements of the organizational environments is based on the analysis of James D. Thompson, Organizations in Action (New York: McGraw-Hill, 1967), p. 28.

Organizational Theory

The purpose of this dissertation is to analyze the role of evaluation in this group of organizations and examine the issue of whether or not organizations can critically evaluate themselves. However, research into these problem areas revealed a closer inter-relationship between them and some important areas of research in the bodies of the literature of organizational theory and public administration including the following: (1) the issue of survival versus goal-oriented models of organizations, (2) the relationship between the "natural" and "artificial" components of organizations, (3) the technology employed by organizations, (4) the issues of accountability and responsibility of public organizations.

The issue of evaluation in organizations is related to the problem of whether or not organizations should be viewed as goal-oriented or survival-oriented systems.³⁸ Important questions are rarely stated as simply as this, because the accomplishment of goals may contribute to the survival of the organization, or the organization may be goal-oriented but to goals other than those that were the basis for which the organization was established. Also, one of the major obstacles to evaluation may be the lack of clarity

³⁸See Amitai Etzioni, "Two Approaches to Organizational Research," Administrative Science Quarterly, Vol. 5 (June, 1960), pp. 257-278.

of the goals of the organizations.³⁹

Following the argument of Mohr, however, we seek to clarify the degree to which evaluation is undertaken to satisfy externally oriented goals or internally-oriented goals.⁴⁰ Distinguishing between the internally and externally oriented goals (or survival and goal-oriented systems) thus reduces itself to the difficult problem of assigning motives. In order to aid in this task, the following guidelines were devised based on "predictions" from the goal and survival models:

(1) Impetus: A basic desire to measure the degree of their success in achieving their goals would be an important and natural component of an organization which corresponds to the goal-oriented model of an organization. The only impetus which a survival-oriented organization would find compelling to undertake evaluation would be that it would lead to the acquisition of funds, whether because evaluation is required by law or because it can be used as a positive argument in obtaining them.

(2) Type of Evaluation: A truly critical self-evaluation carried out by an organization would be likely to be wide in scope, focus on the end goals of the organization, and result in extensive substantive change. A survival-oriented organization would be likely to measure only those goals which it is required to, or measure those which make it look good.

³⁹See, e.g., O. Ruth McQuown, From National Agency to Regional Institution: A Study of TVA in the Political Process (Ph. D. dissertation, University of Florida, 1961).

⁴⁰Lawrence B. Mohr, "The Concept of Organizational Goals," American Political Science Review, Vol. 67 (June, 1973), pp. 470-481.

A second problem area to which the issue of the role of evaluation in organizations is related concerns the relationship between the natural and artificial components of an organization.

In a classic article, Alvin Gouldner notes that organizational theorists tended to focus either on the planned, "rational" components of an organization (e. g., its formal authority structure) or the spontaneous, unplanned components such as sentiments, beliefs, unprescribed social structures, personal enmities and friendships.⁴¹

Both aspects of organization are important and particular emphasis is given here to studying the interaction between the two. It would seem likely that formal, scientific evaluation is likely to encroach on areas which were previously part of the unplanned, natural system aspects of an organization. Indeed, this probability is the basis of much of Wildavsky's argument as to why evaluation cannot succeed; the evaluators will run into opposition from these informal yet crucial aspects of organizations. All organizations have both components or "systems." In attempting to successfully introduce formal evaluation into an organization, an evaluator may

⁴¹Gouldner has pointed out that one problem with using the term "natural system" is that it is not clearly definable but is used as a residual category for all of the unprogrammed elements of an organization. However, until someone develops a more empirically based typology of these "natural system elements," we are forced to use the term anyway. See Gouldner, "Organizational Analysis," p. 410.

emphasize either "artificial" components of the organization, such as authority and technology, or informal, natural system elements such as personal friendships with the other staff of the organization.

Many students of organizations believe that the technology employed by an organization is the single most important factor affecting behavior within organizations.⁴² Technology has been defined in many ways with some writers using it to refer to specific modes of production. However, here the author is using it to mean: (1) the degree of completeness of knowledge concerning cause and effect, (2) the degree to which there are crystallized standards of desirability.⁴³ Taken together, these two factors would seem likely to be important in determining the reception of the evaluation by the personnel of the organization in which it is to be carried out. If there is a great deal of consensus concerning desirable standards and relationships between cause and effect, an evaluation should have a great deal of legitimacy and encounter less resistance and different forms of resistance, if any (e.g., cheating rather than open challenge).⁴⁴

⁴²See, e.g., Charles Perrow, "Some Reflections on Technology and Organizational Analysis," in Modern Organizational Theory, ed. Anant R. Negandhi (Kent: Kent State University Press, 1973), pp. 48-54.

⁴³This is based on the analysis of James D. Thompson, Organizations in Action, pp. 86-92.

⁴⁴Thus, this work examines the perceptions held by members of the organizations concerning the validity of the technology of evaluation. The legitimacy of an evaluative technique refers to the extent to which it is perceived as being both valid and reliable.

However, the technology of the mental health field would appear to fall in the category of technologies where there is relatively little consensus concerning cause and effect or desirable standards.⁴⁵ In such a situation, there would appear to be a great potential for skepticism and resistance to a formal, scientific evaluation. The technologically oriented organizational theorist would predict that a truly developed evaluation technology would be able to overcome such resistance. Others would see technology as being a less important obstacle to formal evaluation than the complex set of norms, beliefs, friendships, and cliques that we call the natural system of the organization. This dissertation explores the extent to which resistance to formal evaluation is based on skepticism concerning the technology of evaluation, natural systems factors, or other reasons.⁴⁶

⁴⁵Thus, there are not only a large number of different types of therapy but also a disagreement concerning underlying models of treatment such as the "medical model" and the "public health model." For a discussion of these issues, see Jerome D. Frank, "The Bewildering World of Psychotherapy," Journal of Social Issues, Vol. 28, No. 4 (1972), pp. 27-44, and Louis D. Cohen, "Health and Disease: Observations on Strategies for Community Psychology," in Issues in Community Psychology and Preventive Mental Health, American Psychological Association (New York: Behavioral Publications, 1971), pp. 55-74.

⁴⁶A distinction is made between the technology of the therapies employed by the personnel of these organizations and the technology of the evaluations used to evaluate the effectiveness of these therapies. For a discussion of the problems of current evaluative techniques, see Gerald Caplan, "The Nature and Problems of Evaluation in Community Mental Health," in Comprehensive Mental Health: The Challenge of Evaluation, ed. Leigh M. Roberts et al. (Madison: University of Wisconsin Press, 1968), pp. 3-14.

While the major focus of this dissertation is on the concept of internal organizational evaluation, the answer to the problem of how critically organizations evaluate their own activities has important implications for the issue of accountability in government. A major text in public administration distinguishes between responsibility (responsiveness to other people's values) and accountability (the methods, procedures and forces that determine what values will be reflected in administrative decisions).⁴⁷ Thus accountability is the method (or methods) used to enforce the responsiveness of public organizations to the values of the public and its representatives. The implicit assumption behind most administration, and particularly in the crucial area of budgeting, is that agencies will not critically evaluate themselves and that responsiveness to the values of the public is maintained only by the review of performance of the organization by someone outside of the organization.

The budgeting system is now basically incremental with little pretense on the part of the legislators of being able to judge the comparative worth of any agency's operation's.⁴⁸ If organizations

⁴⁷Herbert A. Simon et al., Public Administration (New York: Alfred A. Knopf, 1950), p. 513. This distinction is an analytical one because most of the persons interviewed to use term "accountability" to cover both the methods of evaluation and the responsiveness obtained.

⁴⁸See Aaron Wildavsky, The Politics of the Budgetary Process (Boston: Little, Brown, and Company, 1964).

were capable of and willing to provide to legislators, funding agencies, and their local communities information which gives a true and objective assessment of how well they are achieving their goals (as defined by the public and their clientele), the budgetary and political process would be radically altered.

Indeed, the development of scientific evaluation is, in part, the attempt to provide an alternative to "political rationality." Thus, it may be seen as an attempt to provide the equivalent of the market mechanisms of competition and profit which supposedly provide objective criteria of worth to private organizations.⁴⁹ Indeed, many writers feel that most of the differences between public and private organizations relate directly or indirectly to this problem of the lack of objective criteria to judge the efficiency and effectiveness of public organizations as the following list would suggest:

- (1) Public organizations are controlled more by superiors than by the price system.

- (2) Public organizations are based on a type of funding that is highly contingent upon the previous experience and perceptions of superiors.

- (3) Public organizations tend to have more vaguely defined or multiple goals among which cost reduction does not receive very high priority.

⁴⁹Of course, how closely even private organizations correspond to the "ideal" economic model is open to debate with some studies demonstrating the equivalent of a "political mechanism" in private organizations. See, e.g., Richard Cyert and James G. March, A Behavioral Theory of the Firm (Englewood Cliffs: Prentice Hall, 1963).

(4) Public organizations are relatively insulated from automatic penalties and rewards of the price system.

(5) Public organizations lack objective tests of efficiency of product or service.

(6) Public organizations are able at times to shift their costs to other agencies rather than face them or go under.

(7) Public organizations are not generally provided by cost reduction with opportunity for growth.⁵⁰

Most of the attempts or movements to improve the quality of the output of government revolve around either a return to the "economic model" or a turn to the increased use of scientific measures of the effectiveness of public organizations.⁵¹ A few writers have defended the current system of allocation of resources which is dominated by political judgments and incrementalism.⁵² This study explores the factors which help internal evaluators achieve responsiveness to the goals of their evaluations and the conditions under which internal organizational evaluations are likely to provide the "functional equivalent" of external forms of accounting for the purposes of achieving responsibility of public organizations.⁵³

⁵⁰Gary L. Wamsley and Mayer N. Zald, The Political Economy of Public Organizations (Lexington: D. C. Heath and Company, 1973), pp. 5-6. Of course, these are tendencies rather than absolute differences.

⁵¹Milton Friedman has been one of the major proponents of returning governmental functions to the private market. See his book, Capitalism and Freedom (Chicago: University of Chicago Press, 1962).

⁵²See, e. g., Charles E. Lindblom, The Intelligence of Democracy: Decision-Making Through Mutual Adjustment (New York: The Free Press of Glencoe, 1965).

⁵³The use of the term function and other terms related to it follows the usage of Robert Merton. See Robert Merton, Social Theory and Social Structure (2nd ed.; Glencoe: Free Press, 1957), pp. 19-84.

The concept of professionalism is also related to the issues of evaluation and accountability. The mental health organizations visited in this study are, to a large extent, composed of persons who are classified as professionals, including clinical psychologists, psychiatrists, and psychiatric social workers.⁵⁴ One of the characteristics that distinguishes professional occupations is their claim to be self-policing concerning the quality of the services offered by members of the profession: "The profession should be accepted as the final arbiter in any disputes over the validity of any technical solution lying within its area of supposed competence."⁵⁵ This statement would suggest that the newer forms of formal, scientific evaluation would be regarded as an impingement upon the more traditional form of professional evaluation--an issue that is explored here.⁵⁶

Hypotheses and Theoretical Frameworks

Howard Becker has argued that it is useful for individuals carrying out research, particularly research with a great deal of

⁵⁴For a discussion of the criteria by which occupations are classified as professions, see William J. Goode, "The Theoretical Limits of Professionalization," in The Semi-Professions and Their Organization, ed. Amitai Etzioni (New York: Free Press, 1969), pp. 266-314.

⁵⁵Ibid., p. 278.

⁵⁶For a discussion of the alleged lack of accountability and responsibility of professionals, see Elliot Freidson, Professional Dominance (New York: Atherton, 1970).

qualitative material, to give a "natural history" of the course of their work including the selection of their approaches and hypotheses.⁵⁷ The major focus of this research has remained constant and is to explore the role that evaluation has played in these organizations with a particular view to examining the argument that organizations cannot evaluate themselves due to their strong attachments to survival needs. Stated in hypothetical form, this thesis can be summarized as follows:

Due to survival needs, organizations cannot critically evaluate themselves, and any evaluations which they do implement will tend to be narrow, technique-oriented, and symbolic.

Although the above hypothesis is used to focus the analysis of the role of evaluation, this research is exploratory and not directed at the rigorous testing of hypotheses. Rather, this study is more inductive than deductive.⁵⁸ The research revealed several relationships among variables related to evaluation and organizations. These relationships are formally stated as hypotheses at the conclusion of each chapter. However, since these propositions were developed only after the beginning of the research, there is no pretense that

⁵⁷Howard S. Becker, Sociological Work: Method and Substance (Chicago: Aldine Publishing Company, 1970), p. 69.

⁵⁸For an argument that the social sciences should constantly "mix" induction and deduction in research, see Heinz Eulau, Micro-Macro Political Analysis (Chicago: Aldine Publishing Company, 1969), p. 352.

they have been tested here.⁵⁹

As far as theoretical frameworks are concerned, this research employs insights derived from bodies of literature of organizational theory and public administration described above. For the purposes of elegance and simplicity, it is often viewed as desirable to fit research into a single theoretical framework. While such an "integrating theory" is lacking here, all four problem areas of organizational theory are closely interrelated as employed here. Thus, a critically self-evaluating organization would be able to provide accountability to the public without outside intervention and have overcome the problem of the technical adequacy of the technology of evaluation. Such an organization would also have conquered resistance from the natural system and resisted the tendency of organizations to be dominated purely by survival needs.

Methodology

Four kinds of primary data were obtained in this study of these fourteen organizations: (1) participant observation data, (2) semi-structured interviews with directors, clinicians, and evaluators of these organizations, (3) questionnaires from these

⁵⁹Robert Merton has noted the curiosity of "post factum" research in which the evidence always supports the propositions since the latter were formulated after the research was concluded. See Robert Merton, Social Theory and Social Structure, p. 93.

groups of individuals, (4) documents from these and other mental health organizations related to evaluation. The advantage of using more than one technique of data collection is becoming increasingly recognized in research.⁶⁰ Propositions that are supported by more than one method of observation are more likely to be valid than those supported by only one method.⁶¹

The major portion of the participant observation consisted of five months of observation of a community mental health center in which meetings were attended. Evaluation, budgets, organizational goals, and philosophy--all were considered and raised sometimes heated discussion, perhaps because of the youth and flux of this organization which was less than a year old when observation first began. One expert has noted that organizations which are new or are undergoing stressful situations (e. g. , budget cuts) provide especially fruitful material in which to view the dynamics of organizations.⁶²

The author was also a participant observer at meetings of a consortium of mental health organizations which had been formed

⁶⁰See, e. g. , Eugene J. Webb et al. , Unobtrusive Measures: Nonreactive Research in the Social Sciences (Chicago: Rand McNally, 1966), pp. 1-28.

⁶¹Ibid.

⁶²Robert Bogdan, Participant Observation in Organizational Settings (Syracuse: Syracuse University Press, 1972), p. 32.

to study and foster evaluation. These meetings were particularly useful because they were attended by representatives of NIMH and the State Division of Mental Health of the State of Florida. Meetings held by a mental health district board were also observed by this author. Finally, a staff meeting was attended at a second center in which issues, complaints, and general perspective were strikingly similar to those at the original center.

Participant observation is particularly useful in studying concepts which tend to be viewed as socially desirable. Few persons are likely to admit to being "against evaluation." Extended observation is almost certainly less likely to suffer from such a bias because it is difficult for an individual to hide his true feelings in his actual place of work over an extended period of time.⁶³

The interviews followed a form outlined by Merton and others in which certain basic problem areas are explored in depth but with the flexibility to follow-up on useful leads or to abandon obviously "dead" lines of questioning.⁶⁴ Major issues explored in the interviews included the following topics: (1) the role of the evaluator, (2) the methodology of evaluation, (3) the function of evaluation, (4) the problems of implementing evaluation, (5) the impact of evaluation on the organization.

⁶³See Becker, Sociological Work, p. 69.

⁶⁴See Robert Merton et al., The Focused Interview (Glencoe: Free Press, 1956).

The total number of interviews conducted was thirty-five with forty-seven different individuals in these thirteen centers and one clinic. Interviews were carried out with three major groups of individuals: directors, clinicians, and evaluators. Not all of the organizations had an "evaluator."⁶⁵ Comparisons are made between those organizations which were relatively interested in evaluation so as to invest in an evaluator (or evaluators) and those which did not make this investment.

The interviews, with two exceptions, were taped, which makes it possible to present the comments of these clinicians, directors, and evaluators in their own words.⁶⁶ It was found that the months of participant observation enabled the author to ask far sharper questions than would have been otherwise possible, as well as making it possible to supplement abstract questions with specific examples. This tactic was particularly useful when interviewees hesitated in answering delicate questions concerning their own organizations but would not hesitate to answer frankly the same kind of question when it concerned a situation that had been put in hypothetical form

⁶⁵During the study, five of the organizations had at least one person devoted specifically to evaluation. Some of the others were considering the hiring of an evaluator.

⁶⁶For a discussion of the effect taping interviews has on responses, see Raymond L. Gorden, Interviewing: Strategy, Techniques, and Tactics (Homewood: Dorsey Press, 1969), pp. 175-178.

or illustrated from another center.⁶⁷

The questionnaire was constructed in order to provide an indicator of how favorable the different groups (i.e., clinicians, directors, and evaluators) were towards the idea of formal evaluation. It was purposefully kept much shorter than it would have been if it had sought to obtain all the information that was potentially relevant.

This course was suggested by the open hostility of members of these mental health organizations towards the rapidly increasing amount of paperwork to which they had been subjected, including numerous questionnaires from various sources. The implication was that a lower rate of return could be expected if the questionnaire was long and involved. One expert has argued that the dangers of bias from a low rate of return are more serious than the sacrifice of information that results from a shortened questionnaire.⁶⁸

⁶⁷Sam Sieber describes similar advantages resulting from the combination of participant observation and other forms of data such as surveys and interviewing. See Sam Sieber, "The Integration of Fieldwork and Survey Methods," American Journal of Sociology, Vol. 78 (May, 1973), pp. 1335-1359.

⁶⁸See A. Bradford Hill, "Scientific Method in Field Surveys: General Principles of Field Surveys" in Proceedings of a Conference held from March 29 to March 31, 1950, Great Britain Medical Research Council (London: His Majesty's Stationery Office, 1951), pp. 7-13. Sixty-nine of eighty-four questionnaires were returned, although four had to be discarded because they had not been completed.

Plan of the Dissertation

In the following chapter, we shall examine the formal evaluations currently being carried out in the fourteen organizations under study. Each major evaluative technique will be systematically examined through the employment of the dimensions of scope, focus, and impact previously developed as well as other considerations. In Chapter III attitudes towards formalized evaluations will be studied and compared with attitudes towards more subjective forms of evaluation. Particular attention will be given to the problems of resistance to formal evaluation from the "natural system" of the organization and skepticism concerning the technology of formal evaluation. In Chapter IV, we will focus upon the relationship between the survival needs of the organizations and the decision to invest in evaluation. Differences among the organizations with respect to their interest in formal evaluation will be analyzed. In Chapter V, we will examine the relationship between evaluation and accountability and responsibility. Special attention will be given to the factors which increase the likelihood that evaluators will achieve the goals of their evaluation by employing comparisons between internal and external evaluations. In Chapter VI, the major conclusions will be reviewed including the inductive propositions which emerge from the study.

CHAPTER II

THE METHODOLOGY AND IMPACT OF EVALUATION

The purpose of this chapter is to analyze the methodology and impact of each formal evaluative technique that has been introduced in these fourteen organizations. To aid in the analysis, the three dimensions outlined in the last chapter are employed:

<u>Token Evaluation</u>	<u>Critical Evaluation</u>
Scope: Narrow	Broad
Focus: Technique-Oriented	Accomplishment-Oriented
Impact: Symbolic	Substantive

"Scope" refers to the extent to which the evaluation covers the full range of services offered by the organizations. For example, the evaluation may cover the activities of only one particular service such as the outpatient clinic, or it may include the full range of services offered including the inpatient, outpatient, emergency, partial, and educational programs. However, evaluations can be too broad as well as too narrow. In such cases, they are too vague to be able to yield useful information about the quality of specific programs and individual therapists.

The second dimension, "focus," concerns the nature of the goals which the evaluation measures. For example, an evaluation

may focus upon the extent to which service in a particular program corresponds to accepted practice as defined by the supervisory staff of the organization. Yet, whether therapy which is regarded as practicing good "techniques" actually produces desirable "end goals" such as client satisfaction and behavioral changes is problematical.¹ Thus, the focus of an evaluation reveals the extent to which the evaluation is based upon assumptions concerning the relationship between "intermediate" goals and the ultimate goals of the service.

However, there are also important questions concerning what the end goals of these mental health organizations actually are. In a free market model, the satisfaction of the consumer is the major criterion of all exchanges of goods and services because goods and services will be consumed only to the point where the marginal utility derived from them is at least equal to that which could be derived from other goods and services.² Thus, the consumer's willingness to purchase the product or service is proof by itself that the product is worthwhile.

¹Thus, when techniques or "intermediate goals" are focused upon, a whole series of assumptions and linkages may have to be fulfilled if the evaluation is to have its intended effect. See O. L. Deniston, I. M. Rosenstock, and V. A. Getting, "Evaluation of Program Effectiveness," Public Health Reports, Vol. 83 (April, 1968), pp. 323-335.

²See Paul A. Samuelson, Economics (6th ed.; New York: McGraw-Hill Book Company, 1964), pp. 432-433.

With respect to public goods, however, the consumer is not paying the entire cost of the services he receives. Likewise, the community mental health movement began with goals such as reducing state mental hospital loads and the prevention of such behaviors as alcoholism and drug addiction. In fact, the goals of the client of a mental health center may be directly opposed to the goals of significant members of local communities. Such conflict occurs frequently when mental health organizations become involved in activities related to law enforcement and social control.³

The final dimension of "impact" is the most critical single dimension. It indicates whether these organizations take evaluation seriously enough to implement changes in their operations based on the recommendations resulting from the evaluation. However, many of the evaluations have only been recently introduced.⁴ Also, no systematic accounting of the impact of evaluation was carried out within the organizations in which it had been introduced.⁵ As a

³See Allan Beigel, "Law Enforcement, the Judiciary, and Mental Health: A Growing Partnership," Hospital and Community Psychiatry, Vol. 24 (September, 1973), pp. 605-609.

⁴An important qualification of the conclusions reached in this chapter, then, concerns the time period in which this study was carried out. In particular, the impact of the evaluation might be found to be different if undertaken at a later point in time. This point will be discussed further in the next chapter.

⁵The fact that these organizations had not planned to assess the impact of the evaluation in a systematic way is interesting in itself because of the costs of the evaluations. It is also to be discussed later.

consequence of the above reasons, interviews are used here as the basic source of information concerning the impact that each evaluation has had.

Table 2.1 summarizes the major categories of evaluative techniques which had already been introduced or were in the planning stage at the time of this study. All meet the criteria of formal, scientific evaluation introduced in the first chapter.

TABLE 2.1
SUMMARY OF EVALUATIONS

	Consumer Satisfaction Surveys	Goal Attainment Models	Needs Assessment Surveys	Problem- Oriented Records
Introduced	4	3	3	1
Planned	5	4	1	1
Total	9	7	4	2

In addition to the above categories of evaluation, there were several other techniques which either were confined to one organization or were on the borderline as to whether they met the criteria of formal, scientific evaluation.⁶ Each of these methods is examined with respect to the three dimensions of scope, focus, and impact.

⁶As noted previously, our most basic distinction between scientific and nonscientific evaluations is whether they are open to retesting by someone other than the original evaluator (or evaluators).

Additional considerations which are relevant to the problem of the role of evaluation are also noted.

Consumer Satisfaction Surveys

Table 2.1 reveals that the single most popular evaluative technique employed in these organizations is the consumer satisfaction survey. These surveys generally measure an individual's overall reaction to the service he receives. An example of one such survey in Table 2.2 shows that extremely broad questions are asked. These questions do not discriminate between satisfaction with different programs much less individual therapists. This lack of discrimination makes it difficult to make specific recommendations from this kind of survey. The dissatisfaction of an individual client may be a generalized displeasure towards the entire center but it may also be resentment at a particular program, individual therapist, or the attitudes of the receptionists.

Thus, consumer satisfaction surveys usually provide information that is too broad in scope to be useful in making decisions. These surveys can be made more specific in order to acquire more useful information. However, even these very short and simple surveys get generally low rates of return from the clients to whom they are sent. Centers expect to receive only about 15 to 25 percent of the questionnaires mailed out. Furthermore, a large percentage of the

TABLE 2.2

EXAMPLE OF A CONSUMER SATISFACTION SURVEY

(1) Did you have any problems getting service at _____
Mental Health Center? Yes ___ No ___

(2) Were there any services you felt you should have received and didn't? Yes ___ No ___

(3) Were you satisfied with the services you received?

Very Satisfied ___

Satisfied ___

Indifferent ___

Dissatisfied ___

Very Dissatisfied ___

(4) Would you return to the Mental Health Center if you felt a need for further services? Yes ___ No ___

(5) Do you feel different about your problems now?

Much Better ___

Better ___

Same ___

Worse ___

Much Worse ___

(6) Do you attribute this to the treatment you received at the Center?
Yes ___ Partly ___ No ___

Source: Adapted from "Cumulative Report on Patient Satisfaction with the Mental Health Center," P. E. P. Newsletter Compendium (Minneapolis: Program Evaluation Project, n. d.), p. 13.

clientele of most centers are relatively uneducated and do not understand complex questions. In short, with a more detailed survey the evaluators would risk an even smaller and more biased sample of responses than they presently get.

Certain organizations used interviewers to gather part or all data for the consumer satisfaction surveys. Using interviewers tends to sharply increase the percentage of clients responding to the survey but it also greatly increases the cost. The problem of securing useful information from consumer satisfaction surveys involves finding the proper scope and a representative sample. Both of these objectives must be compromised because of the urgent problem of scarcity of resources. Therefore, most of the organizations took the option of having a very general set of questions administered through the mail despite the problems of interpretation and bias that result from this type of survey.⁷

The satisfaction of the clientele of an organization is certainly a major goal of public agencies.⁸ Indeed, some directors and clinicians argued that the satisfaction of the clientele should be the only goal of these organizations. Yet, as was pointed out earlier, these organizations receive most of their funds from public taxes,

⁷One organization did construct a much more detailed consumer satisfaction survey and planned to use interviewers to carry it out.

⁸See Aaron Wildavsky, The Politics of the Budgetary Process (Boston: Little, Brown, and Company, 1964), p. 66.

which means that they must be responsive to the values of the general public and not just the recipients of their services. Often the goals of the general public and groups such as the family of the clientele are in open conflict with the goal of satisfying the patient. The public is usually interested in keeping the costs of these public organizations as low as possible. The family often wishes to keep the client away from home. The following director notes the incompatibility that often occurs between satisfying the patient and satisfying his family or the public:

(Director) I find that most of the people who come to my office dissatisfied with the service are dissatisfied because they wanted the treatment to go in one direction and the physician wanted the treatment to go in another. I think that this is especially true with the family, who say, "Hell, this guy came in and you recommended him for outpatient treatment. Hell, I wanted him sent to the State Hospital. Keep him locked up. I don't care what you do with him. Don't send him back to us." Many of the patients are perfectly happy to be hospitalized in the inpatient unit. It is heated, lighted, and air-conditioned. It is a hell of a lot better than the homes of the ghetto. And the clients are not particularly satisfied with the service when they are being discharged.⁹

In short, consumer satisfaction surveys focus upon one of the important goals of these organizations, but the public holds other goals for these organizations than simply satisfying their clientele.

⁹In this example the conflict between the satisfaction of the client and the goals of the public concerns the desire of many of the clients to remain in the expensive inpatient unit which costs more tax dollars to support than the less expensive outpatient clinic.

However, a more serious objection to consumer satisfaction surveys is that they do not truly measure the quality of service that clients receive. Some directors and clinicians pointed out that a large percentage of poor clients had never had any form of treatment previously and were likely to be satisfied with virtually any attempt to help them. Indeed, every consumer satisfaction study examined by this author was highly positive, with 70 percent or more of the clientele of various mental health centers judging the services to be at least satisfactory if not excellent.¹⁰ By way of contrast, evaluations which focus upon behavioral changes tend to be negative.¹¹ A cynic would argue that the likelihood of positive findings explains the popularity of the consumer satisfaction survey. Certainly, the uniformity of these highly positive results makes it impossible to use these surveys to distinguish between those organizations which are doing a better than average job and those which are doing a

¹⁰See, e. g., Gerald Landsberg, "Consumers Appraise Store-front Mental Health Services," Evaluation, Vol. 1, No. 2 (1973), pp. 66-76, and James B. Goynes and Paulette Ladoux, "Patients' Opinions of Outpatient Clinic Services," Hospital and Community Psychiatry, Vol. 24 (September, 1973), pp. 627-628.

¹¹For examples of resistance to behaviorally-oriented evaluations, see George Fairweather, et al., Community Life for the Mentally III: An Alternative to Institutional Care (Chicago: Aldine Publishing Company, 1969), p. 341 and G. M. Carstairs, "Problems of Evaluative Research," in Community Mental Health: An International Perspective, ed. Richard Williams and Lucy Ozarin (San Francisco: Jossey Bass, 1968), pp. 44-62.

mediocre job. On the other hand, such studies may provide a useful check against really poor centers. If a consumer satisfaction study finds a low rate of satisfaction, something may be wrong.

Despite its popularity among these fourteen organizations, there were few examples of the use of the consumer satisfaction survey for changing the operations of the organizations. In a few instances, it did provide feedback that aided in discovering problems of the organization:

(Evaluator) One of the things that our evaluation has made us aware of is the fact that we have to be always concerned with a waiting list for our clinic because we see ourselves as a crisis intervention center. One specific example occurred when we had a psychiatric consultant who came two days a week for a while. His primary role had never been defined clearly. But we became very much aware through our program evaluation project that on the days that he was there, people waited for long periods of time in the waiting room. It made the people upset. We traced it back and found out that he was not just handling the medication as we had supposed. He was doing psychotherapy and taking an hour or more out of necessity. We defined his role more clearly as taking care of medicine only. If any need for long term therapy arose, he would channel the patients to us. Things went much smoother.

Other directors argue that they can secure the same information without conducting a formal consumer satisfaction survey by simply listening to complaints registered by clients. However, it is possible that there are situations in which a director or program head finds such information useful in convincing others in the

organization to change the nature of their operations.¹²

Another clinician admitted that very general questions were asked in these surveys but noted that sometimes useful information about the overall flow of the Center's operations turned up:

(Clinician) We made up our own consumer satisfaction scale which was quite elementary with obvious questions such as, "Are you happy with the service you received?" We had ten questions like that. I think it was very useful. We began to look to see what was happening dispositionally to the cases and were quite surprised to find that in most of the cases, people were seen only two or three times. It revamps some of our thinking about ourselves. It is sort of taking a survey of how the system flows. It is an evaluation of another sort.

Again, it is likely that alert therapists and administrators already have an idea of how many (or few) times they see their clients, but these surveys may be useful in providing quantitative proof of such suspicions.¹³

A curious finding is that many directors of the centers did not expect to get much useful information from these surveys.

¹²For example, the use of objective data to reduce the mutual tension involved in giving negative feedback to a subordinate has been pointed out by Peter M. Blau, The Dynamics of Bureaucracy (2nd ed.; Chicago: University of Chicago Press, 1963), p. 43.

¹³However, clinicians at centers which had not undertaken such surveys specifically mentioned the fact that they saw their clients, on the average, only two or three times. They went on to argue that this limited contact seemed to be a good reason not to do a formal evaluation because the effects of the therapy were not likely to be great under such conditions.

Despite this fact, they carry them out anyway:

(Director) We are going to do something because we feel we have the capability. We just put in a computer system. We feel that we have the capability of carrying out some sort of evaluation. It [the consumer satisfaction survey] consists of twenty questions. Basically, we are asking what patients think about the Center. It will go out to all of the new patients seen in the last year, about 4,000. A second phase will be to go out and do personal interviews with about 300 randomly selected patients. With these two instruments, I think we will get a pretty good idea not whether we are doing anything, but whether the patients think we are doing anything.

One director questions the ability of the clients to give an objective appraisal of the services they receive:

(Director) Well, I will be surprised if it shows me something that I didn't already expect. Most of the people (and I will be surprised if we get much more than a 15 percent response) probably will be tremendously angry or pleased with the Center because either it didn't perform all of the miracles it was supposed to perform or because it was a nice place and people care. I think probably both of these groups will be sending the questionnaires in. . . .

The directors of centers that had not carried out such surveys often argue that similar information can be collected in less expensive ways:

(Director) No, I don't think it would be useful [i. e., undertaking a consumer satisfaction survey]. In this particular consumer satisfaction study [he is referring to a consumer satisfaction study he had read about in a journal] 85 percent said they were satisfied. I would expect that if we sent out a similar questionnaire, that by and large, we would get similar results. Because most people are satisfied with the treatment. The reason why I say that is if they weren't satisfied with the treatment, I think that the population is vocal enough to let it be known that they are not. I can personally say that because this office is where a lot of the complaints come.

Consumer satisfaction surveys were not perceived by the center staff as threatening. Using such surveys to introduce a program of research and evaluation to the staff is one of the positive examples concerning their impact:

(Clinician) The first thing that it [consumer satisfaction survey] accomplished was that it introduced the staff generally to the concept of evaluation. I think that everyone knows that that is the first big step.

However, in summary, there were only a few, isolated examples of cases where the consumer satisfaction surveys had influenced decisions concerning the delivery of services. Even more significantly, the surveys are not generally expected to have much impact on the decision making of these organizations.¹⁴ Nevertheless, significant amounts of time and money are being devoted to carrying them out.

Goal Attainment Scaling

The goal attainment scaling method of evaluation embraces a wide range of specific methods including the following major variations:

(1) Original Method: As originally developed at the Hennepin Mental Health Center in Minneapolis, Minnesota, goals are set for the client by an intake worker. Then the client is assigned to a particular form of treatment. After

¹⁴Here, the author is referring to the internal decision making of the organizations. In later chapters, other types of functions of evaluation will be examined, such as use in influencing funding agencies.

a specified length of time, a follow-up worker interviews the patient in order to ascertain to what extent the goals set at intake have been fulfilled.

(2) Contract Fulfillment Analysis Methods: With this method, goals are set by negotiation between the therapist and the client. However, the degree of goal attainment is determined as in the above method, with a follow-up worker interviewing the client to see to what degree goals have been attained.¹⁵

(3) Standardized Methods: In these forms, there are sets of prespecified goals categorized according to problem areas. Due to its standardization, it has been possible to computerize this form, in contrast to the above forms in which everything is done by hand.¹⁶

Elements common to all forms of the goal attainment model of evaluation include the following: (1) a six-point scale is used to determine the degree to which a goal has been attained, ranging from the "most unfavorable success" to the "best anticipated success"; (2) the goals are weighted according to their degree of importance by the person (or persons) who sets the goals; (3) after therapy has been completed, a single goal attainment score is computed based on the degree of goal attainment for each individual goal set and its "weighted importance."¹⁷

¹⁵This description is based on Collier County Mental Health Clinic, "Progress Report on Program Evaluation Project," Naples, Florida, n. d. (Mimeographed.)

¹⁶See Nancy C. Wilson, "The Tri-Informant Goal-Oriented Progress Note" (Paper presented at the American Psychological Association, Honolulu, Hawaii, 1972).

¹⁷See Thomas J. Kiresuk and Robert Sherman, "Goal Attainment Scaling: A General Method for Evaluating Comprehensive Community Mental Health Programs," Community Mental Health Journal, Vol. 4 (December, 1968), pp. 443-453.

The major differences among the many versions of goal attainment evaluation concern mainly the issues of who sets the goals and what types of goals are to be included. In some forms, only the therapist is involved in the setting of goals. In others, not only the client but family members or others become involved in the goal-setting.¹⁸

The originators of the goal attainment method of evaluation put a great deal of emphasis upon having behavioral indicators for each of the more generalized goals set. Thus, for the treatment of drinking problems, specific amounts of alcoholic intake might be set as the means by which the level of attainment is measured. Recently, there has been a movement towards the inclusion of concepts for which it is difficult if not impossible to use this kind of measure, such as "self-concept" goals.

Finally, there is a distinction between those centers in which an individualized goal is constructed anew for each client and other centers in which lists of pre-set goals are used. These lists include both behavioral and non-behavioral goals. Some examples are given below:

¹⁸See Nancy C. Wilson, "The Tri-Informant Goal-Oriented Progress Note."

<u>Category of Goals</u>	<u>Specific Goals</u>
(1) Medical Goals	(1) Gain or lose weight, reduce or stop drinking, improve nutrition
(2) Symptom Goals	(2) Motor Behavior (e. g. , posturing), sexual behavior (e. g. , exhibitionism), activity disorders (e. g. , hyperactivity)
(3) Self-Concept Goals	(3) Self-regard, self-trust, self-confidence in various abilities, changing independence, appropriate handling of feelings. ¹⁹

The standardized form includes items to indicate the level of success that is expected to be attained and the degree of importance attached to each goal.

Taken together, the various forms of goal attainment evaluation represent the single fastest growing type of evaluation in community mental health centers and are also achieving a rapid diffusion to fields other than mental health.²⁰ In addition, the reliability of the goal attainment scores has been tested and found to be fairly high.²¹

¹⁹These examples are taken from a form developed by Nancy C. Wilson of the Fort Logan Mental Health Center, Denver, Colorado.

²⁰See Howard Davis, "Four Ways to Goal Attainment: An Overview," Evaluation, Vol. 1, No. 2 (1973), pp. 43-48.

²¹See Geoffrey Garwick, "First Reliability Report for Goal Attainment Scaling," P. E. P. Newsletter Compendium (Minneapolis: Program Evaluation Project, n. d.), p. 54.

The scope of the goal attainment method is impressive because this same technique can be applied to all types of programs, both direct and indirect.²² Although the goal attainment score is calculated for the success of the service delivered by an individual clinician, the scores of several clinicians can be averaged together to give a goal attainment score for an entire program.²³ The goal attainment method has even been applied to the evaluation of the administration of a mental health organization.²⁴ One potential limitation of the scope of this evaluation technique involves those forms which require the active cooperation of the client in ascertaining the goals to be set for him. This cooperation may be impossible to achieve when the patient is in a highly agitated state.²⁵ A more important limitation of goal attainment scaling is that the model has not yet been related to the budget and other important areas of organizational

²²Indirect services refer to programs such as consultation and education. In these programs, the "client" is not experiencing difficulty but is taught how to better handle people who do experience psychological problems. These programs are particularly aimed at groups who come into frequent contact with individuals, such as clergymen, policemen, and teachers.

²³However, this form of evaluation does not enable clear distinctions to be made between the effectiveness of different programs. Its focus remains the individual interaction between therapist and client.

²⁴See Sander Lund, "Crisis Intervention Center: Administrative Evaluation," P. E. P. Newsletter Compendium (Minneapolis: Program Evaluation Project, n. d.), p. 86.

²⁵This is often the case for clients admitted to the inpatient unit of a mental health center.

decision making.²⁶

The focus of goal attainment evaluation is much sharper than that of consumer satisfaction surveys. Specific goals are set in contrast to the very generalized questions which are characteristic of consumer satisfaction surveys. However, despite the satisfactory results from testing the reliability of the goal attainment scores, the validity and interpretation of the scores is still open to question.

There is the definite problem of bias in the report of the degree of goal attainment because these scores are determined in large degree by the report of the client. The former client may perceive the failure to achieve the goals of the therapy as reflecting upon himself rather than the therapist.²⁷ Such a client would tend to over-report the success of the therapy.

Another problem concerns the interpretation of the scores. A large percentage of the clients of many of these centers receive drugs as part of their treatment. One director points out that in such cases it is impossible to determine whether the therapy or the drugs is responsible for any improvement that may occur in

²⁶Recently, however, attempts have been made to do this. See Joseph Halpern and Paul R. Binner, "A Model for an Output Value Analysis of Mental Health Programs," Administration in Mental Health (Winter, 1972), pp. 40-51.

²⁷Indeed, most clinicians agree that the client plays a big role in determining the success of the therapy. This point will be discussed further in the next chapter.

the client's condition.²⁸

Bias can also result from the participation of the therapists and follow-up workers in the scoring of the degree of success. There is substantial evidence that factors other than "objective improvement" are likely to affect this rating.²⁹ Even when behavioral indices are constructed to determine the degree of success, the scores are still based on reports and perceptions of change rather than actual observation of these changes under controlled conditions.

Some clinicians and evaluators think that the validity of goal attainment data is even more suspect when "non-behavioral" goals such as self-concept are included:

(Clinician) Say that I ask you, "What do you want to do?" And you say, "I want to become a better person." And then, after I have completed the therapy, I ask you, "Do you feel like a better person?" You say, "Yes." And I say, "Goal Accomplished." And what the hell has happened? I would prefer something more behaviorally-oriented but it wouldn't sell right here, at this center. . . .

(Evaluator) Yes, I don't see how that can be done [i. e., use the goal attainment method for non-behavioral goals]. I personally favor the behavioral definition. . . . The Center uses a referral form and the teachers check off the items that are on the form. I was perturbed when I

²⁸Approximately 70 percent of the clientele were administered drugs in the organization in which the author was an observer.

²⁹See, e. g., Jim Mintz, "What is 'Success' in Psychotherapy?" Journal of Abnormal Psychology, Vol. 80 (February, 1972), pp. 11-19.

saw the form as it has been used in the past because there are things like poor self-concept on it. Now, how the hell is the teacher going to know what the kid's self-concept is? I think even the psychiatrist would have quite a bit of trouble getting at that self-concept. You know that I personally favor definitions that are observable.

Due to its sharper focus, the goal attainment method of evaluation appears to be more likely to be used by therapists. This feedback concerning the degree of success which he has achieved with various clients may be quite useful for the therapist and enable him to improve his effectiveness. However, there are no data to back up this contention. Goal attainment scaling was implemented in a completely non-threatening way in which careful attention was given to keeping "negative feedback" confidential. Two different evaluators described at length the care that was given to avoid threatening therapists with such information:

(Evaluator #1) I can tell you what we did. We have made it extremely confidential. We discussed what to do with negative feedback and decided that the only one to see the results would be the follow-up worker. We decided the thing was confidential. It ended up as a joke that we were getting our report cards. So the follow-up worker was the only one who knew the results and tallied them up and put them in an envelope. We decided to provide all of the positive comments but only negative ones if there were some consistency and left it up to the judgment of the follow-up worker.

(Evaluator #2) Well, you would go through the proper channels with a negative evaluation. It would be unthinkable to come up with something like this without airing it out. For one thing, you would lose the trust and confidence of the people, and just hurt yourself. If the Center director wants to make an issue of it, that is fine. The point is that I would present a statement to the Center director including

my feelings as to what should be done. I wouldn't say, "Do this or I will quit."

The only evidence of substantive impact of goal attainment scaling is a generalized feeling on the part of those therapists and directors committed to it that it more clearly defines the purposes of the therapy:

(Director) Yes, I think the unit which had introduced goal attainment scaling is much more comfortable in getting a handle on whether their clients are getting any help or not. I know that they use that as a way to structure the program for individual clients. They seem pretty well satisfied with it.

(Clinician) One is that goal attainment scaling in each encounter gets the client involved in the setting of goals. Many patients find that really useful. It defines why they are coming. It also gives them a stepladder on which to decide, "Did I or did I not achieve it?" For example, one of the goals might be to get a job so the expected level might be that in the next two weeks the person has made an attempt to get a job. The highest level might be that he has made twenty attempts to get a job. Most of the time people come in and complain about behavior. They don't like what their boss is doing or what they themselves are doing.

There are no "hard data" to indicate that the effectiveness of the therapy increases after the introduction of goal attainment scaling. Also, other than being used to provide confidential feedback to individual therapists, it does not appear that goal attainment evaluation has any highly visible impact on the operations of these organizations.

The sharper focus of goal attainment scaling creates the potential for conflict between different philosophies and methods of treatment. One director noted that the method seems to be helpful

in one program but that he would hesitate to introduce it in other programs:

(Director) It was easy for the one particular service to implement because they only had a staff of six people. The director of the service is behaviorally-oriented and had a great deal of personal faith and belief in the need for this. He communicated this to his staff. Then the staff adopted the attitude of the director. But with a variety of programs and directors of various faiths--it is more difficult.

A psychodynamically-oriented clinical psychologist indicates his opposition to the general concept of setting specific goals for the therapy:

(Clinician) Yes, if you are going to look at treatment in those kinds of behavioral terms, I think this is where my approach and [name of another therapist] differ. He very clearly sets up goals and motivation whereas I don't presume motivation. I don't give the patient credit for being able to verbalize motivation or goals. There are probably a lot of things he doesn't know he is doing, wants unconscious. . . . Sometimes I have no specific goal.³⁰

Except when goals are standardized, it is difficult to make comparisons between different therapists with the goal attainment method of evaluation. Therapists with lower goal attainment scores can claim that they simply are setting more ambitious goals than the others. Standardization of goals is likely to facilitate the use

³⁰Nearly every form of evaluation presumes a goal. However, note what Michael Scriven has called "goal-free evaluation." See Michael Scriven, "Prose and Cons About Goal-Free Evaluation," Evaluation Comment, Vol. 3 (December, 1972), pp. 1-4.

of this form of evaluation for use in making decisions, as the following director argues:

(Director) My own personal bias is towards something that has a little more standardization. I guess I am a little more systems-oriented. I like to be able to make some kinds of comparison which I don't think that you can do very well with goal attainment scaling [i. e., the unstandardized forms]. So, I would probably lean toward something that is a little more standardized.

However, attempts to standardize goals also are likely to run into opposition. The following director describes the reasons for opposition to the goal attainment method of evaluation and particularly to the more standardized forms:

(Director) I think it [goal attainment scaling] sounds good, but in therapy it is not that simplistic. Our goals keep changing. I think that there is a value in that--in having a leeway in the kind of goal that you are trying to obtain. I would hate to see the day when NIMH tells us that we had to have this kind of evaluation because I don't feel that we have reached the state where we can set up definite goals or that they should depend on the patient.

In short, goal attainment evaluation is likely to have a positive impact on therapy only when those using this form of evaluation agree with its purposes and feel that it would be useful. Otherwise, it is likely to have a negative impact on the work of the therapists.

To summarize the impact of goal attainment scaling, it has been used mainly to provide feedback to the therapists concerning the results of their therapy. Some clinicians and directors felt that it has enabled both therapists and clients to get a "better handle" on the purpose of the therapy. However, there was no systematic

attempt to test the assumption that it has led to greater effectiveness of the therapists.

Goal attainment scaling evaluations, like consumer satisfaction surveys, consume significant resources of the organizational staffs. If taken seriously, the goal attainment forms require a large amount of the therapist's time.³¹ A follow-up worker is also needed in order to measure the degree of attainment.

However, despite the resources of time and staff being devoted to this form of evaluation, it was not actively used in making the major decisions of the organization, such as those related to the budget. It generally was introduced in such a non-threatening way that it was also not used to make major personnel decisions either.³²

Epidemiological Surveys

Psychiatric epidemiological surveys attempt to measure the incidence, prevalence, and distribution of mental illness in a particular area.³³ Such surveys can be used as evaluative tools

³¹See Gregg Wahlstrom, "A Clinician's Reaction to Goal Attainment Scaling," P. E. P. Newsletter Compendium (Minneapolis: Program Evaluation Project, n.d.), pp. 43-44.

³²The reasons for the non-threatening way that these evaluations were used are explored in following chapters.

³³These surveys are also called "needs assessment surveys." However, the latter term is also used to refer to surveys which measure general needs and do not use psychiatric definitions of mental illness or the methodology of survey research.

in at least two ways: (1) to compare the populations which the epidemiological surveys show to be in the worst state of health with those being served by the mental health centers in order to see if the center is reaching those most in need; (2) to repeat the survey after a given period of time in order to see if the organization has been successful in decreasing the occurrence of mental illness.

Psychiatric epidemiological surveys are not designed to provide feedback on the quality of the programs or therapists of mental health organizations. In certain cases, a program may have the responsibility of treating a particular group of persons who can be identified by the surveys such as a particular problem group (e.g., alcoholics) or age group (e.g., children). In such cases, if the prevalence and incidence of mental illness change markedly for the better or worse in comparison with the rest of the population, the results of the epidemiological surveys may actually have fairly clear implications for individual programs.³⁴ Generally, however, these surveys are aimed at testing certain relationships that do not have any direct utility for individual therapists or programs.³⁵

³⁴In one case, certain practitioners were allowed to put items into the survey that they felt might provide useful information for the programs of which they were members.

³⁵For evidence supporting this statement, see below.

If everyone were agreed as to the definition of mental illness and health, and how they could be measured, then it could be strongly argued that epidemiological studies approach as closely as is possible a truly accomplishment-oriented evaluation. However, no such consensus has yet been reached concerning how to define mental illness or health.³⁶ Moreover, epidemiological surveys have produced great ranges in the extent of psychiatric "impairment" found in the populations studied, ranging from a few percent to more than 50 percent.³⁷ It is apparent that different operational definitions of mental illness can lead to large differences in the amount of mental illness found and the conclusions reached from such a survey.

Another problem with epidemiological surveys is that they violate the concept of community mental health by attempting to apply a single standard of mental health to all communities, regardless of the particular value systems of these communities. Indeed, several clinicians, particularly those in the rural areas, noted the fact that the communities they served tolerated individuals which other communities would regard as extremely deviant. There

³⁶For a summary of several different approaches to the concept of mental illness, see S. B. Sells, ed., The Definition and Measurement of Mental Health (Washington: Government Printing Office, 1968).

³⁷See Bruce P. Dohrenwend and Barbara Snell Dohrenwend, "The Problem of Validity in Field Studies of Psychological Disorder," Journal of Abnormal Psychology, Vol. 70 (February, 1965), pp. 52-69.

are current efforts to develop more "neutral" definitions of mental illness.³⁸ Until a greater consensus is reached on both conceptual and operational definitions of mental illness, debates concerning the validity and utility of these surveys are likely to continue.

The most serious problem in using epidemiological surveys as evaluative tools is the lack of clarity concerning their meaning. Many variables other than the quality or quantity of mental health services provided by mental health organizations affect the degree of mental illness found by epidemiological surveys. Some of these extraneous factors are population shifts, socioeconomic conditions, general cultural trends, and the impact of other public agencies.

At one Center where the author was an observer, the evaluator asked a psychiatrist how he thought the quality of the services of the Center should be evaluated. The psychiatrist replied that the "only way to do it" was to carry out an epidemiological study and repeat it after a certain interval in order to see to what extent the figures on prevalence had changed. Later, however, in a discussion involving the psychiatrist, the evaluator, and a consultant (who was

³⁸For an illuminating account of the differences between providing services in a rural setting and an urban setting, see Hans R. Huessy, "Tactics and Targets in the Rural Setting," in Handbook of Community Mental Health, ed. Stuart E. Golann and Carl Eisdorfer (New York: Appleton-Century-Crofts, 1972), pp. 699-710. Huessy concludes that practices that are regarded as good technique elsewhere can lead to damaging results in rural areas.

an expert on needs assessment surveys), even the psychiatrist admitted that the epidemiological survey would provide ambiguous data:

(Consultant) Can you use an epidemiological instrument to evaluate the impact of programs? I am not entirely convinced that you can.

(Evaluator) It is very difficult to tell whether or not the change was the result of the Center or other factors. . . .

(Psychiatrist) I still think that it is a good instrument. Someway or another, we have to decide whether or not we are doing a good job.

(Consultant) But, take, for example, a case in which several DWI's [persons arrested for driving while under the influence of alcohol] are arrested here while passing through this county. That goes into the records as increasing the amount of alcoholism in this country. . . .

(Psychiatrist) Or you could argue that it might have been worse if we weren't in operation. That is what I was prepared to do if the results turned out bad.

Thus, it is difficult, if not impossible, to draw conclusions about the quality of the services of mental health organizations based on the results of epidemiological surveys.

In one Center, the epidemiological survey was used to determine the proper location of a mental health service so that it would be close to the most highly impaired area. Another Center used one such survey to locate their outpatient clinic. The survey found that nearly everyone went to the same general practitioner in this

catchment area.³⁹ According to the personnel of this Center, this doctor had been prescribing medicine without knowing what kinds should be administered for psychological problems. When the outpatient clinic was located near his office, he agreed to refer patients with psychological problems to this clinic. Thus, epidemiological surveys appear to be of use in making decisions of where to locate services.

Otherwise, there was little evidence that epidemiological surveys influenced the internal decisions of these organizations. As was the case with consumer satisfaction studies, many of the directors of the centers undertaking these epidemiological surveys argued that they could anticipate the findings. The author asked one director why he had undertaken these surveys if he already knew what the results would be:

(Director) As I indicated before, they are necessary because you can't take things for granted. For example, in one area we never had any patients, but the minute we opened the clinic we were overflowing with patients. The other reason is that it is important in selling the programs to the community in order to get community funds. You can't go to them without scientific data. You won't get it then. Today you have to have scientific data. They will say, "Now let me have the data that show how many and where the people are who need these services." So it is an excellent tool for helping to obtain funds.

³⁹"Catchment area" refers to the area and population which these organizations are responsible for serving.

As the above interview demonstrates, the purpose of the epidemiological surveys seem more directed to justifying increases in the funding of the organizations than to using them internally.⁴⁰

Psychiatric epidemiological surveys, like the rest of the evaluation, involve significant costs of time and money. In fact, where these surveys were being carried out, they were consuming more time than any other single research activity.⁴¹ Yet, the feedback from such surveys is not obtained until months or even years after the beginning of the survey. Also, the information obtained from them is far from being clear or useful for the making of most organizational decisions. These disadvantages led one evaluator to admit that she would prefer to work on something that the clinical staff would find to be more useful:

(Evaluator) Yes, the epidemiological survey was my main purpose for coming down here because I had already worked with the instrument. But the things that I am now interested in, the research that really turns me on, are those things which I can see will be useful in the organization such as a follow-up study on people who called up for an appointment and are not coming back to keep the appointments for some reason. This is something that could lead to actual changes and affect the patient.

⁴⁰This point is discussed further in later chapters.

⁴¹For an argument that much less expensive and time-consuming epidemiological surveys can be carried out, see R. David Mustian and Joel J. See, "Indicators of Mental Health Needs: An Empirical and Pragmatic Evaluation," Journal of Health and Social Behavior, Vol. 14 (March, 1973), pp. 23-27.

Clinicians, while admitting that the information would be interesting when collected, found that they had much more pressing demands for direct services. These demands were making it impossible for them to participate in carrying out the needs assessment survey:

(Supervisory Clinician) I approached the evaluation staff to do a follow-up study for patients seen in the clinic in order to get an overall view of the community attitudes towards the patient, and also to get some impressions from other agencies, but we haven't done this because we are in the midst of a needs assessment study. I think that the needs assessment study is very valuable. We don't really know the extent of mental illness, of alcoholism, and where the people go for service. But it is going to take a lot more effort than we are putting into it right now. It is difficult to have my staff spend four or five hours a week on it as they are now and . . . cut. . . our other programs. We have figured out that it would take three years to complete the study. In three years, well, the results would be invalid--if you spread it over that length of time. I don't know what is going to happen unless they have the money to hire interviewers to go out and do some interviews.

In short, when the staff sees significant amounts of resources being spent on an activity which it sees having little substantive impact on the organization, it is likely to question its value.

Problem-Oriented Records

The fourth kind of scientific evaluation used is problem-oriented records. The idea behind problem-oriented records closely parallels the concept of program budgeting. It sets up a record system organized around the problems of the patient rather than the usual system in which the categories are not systematically related

to the problems of the client.⁴²

As an evaluative tool, problem-oriented records make it possible for there to be a better auditing of the patient's treatment and progress.⁴³ Specific plans and goals are indicated in the records for each client. More specifically, a problem-oriented record system normally consists of the following major components:

(1) Data Base: This base includes a history of the client, his present illnesses, and the results of any examination and tests that have been carried out on him.

(2) Problem-List: This list can include both the complaints of the patient, the analysis of the therapist, and the problems indicated by the tests performed on the patient.

(3) Plans and Goals: A specific plan and goal is associated with each problem in the problem list.

(4) Follow-up: The follow-up includes progress notes and further feedback concerning old problems or new problems.⁴⁴

Ideally, each of these four components is carried out in sequence with the feedback from the follow-up being used to start the whole sequence over again with new data, new problems, and so forth.

⁴²This is analogous to the concept of program budgeting which attempts to get away from the type of budgeting which is divorced from the functional activities performed by public organizations. See Leonard Merewitz and Stephen Sosnick, The Budget's New Clothes (Chicago: Markham Publishing Company, 1971).

⁴³See Robert W. Putsch et al., "Quality Care, Problem Orientation, and the Medical Audit," in The Problem-Oriented System, ed. J. Willis Hurst and H. Kenneth Walker (New York: Medcom Series, 1972), pp. 173-182.

⁴⁴This description is based on Harold Cross, "The Problem-Oriented System in Private Practice in a Small Town," in Hurst and Walker, ibid., p. 157.

The scope of the problem-oriented record system is broad because it can be applied to all interventions for which specific problems and goals can be identified. Quantitative goals may be made for the client depending upon the particular way that the evaluation is introduced. In contrast to the goal attainment method of evaluation, there is no standardized, single score that represents the total success of the therapy. The lack of such an index makes it difficult to make comparisons between therapists.

The focus of problem-oriented records is technique-oriented rather than accomplishment-oriented. Keeping good records is not an end in itself but the ultimate goal is to achieve a better quality of service. Thus, there are some important linkages involved in order for better treatment to result from better record-keeping including the following: (1) the therapists have to be taught how to keep the records in the new form; (2) they have to carry out the system faithfully rather than merely giving it "lip service"; (3) the records would have to be reviewed regularly and recommendations made to reinforce good practices and eliminate bad practices; (4) the therapists would have to carry out the recommendations made on the basis of the record system. Finally, the whole system depends upon the assumption that the record system measures the quality of service accurately enough for useful suggestions and better practices to result from it.

The assumption that keeping better records leads to better practices is challenged by the director of a Center in the following exchange:

(Director) I feel that we need to have somebody look into the efficiency of the organization, perhaps staying a month or two in every location. It might be threatening but it is likely to help.

(Evaluator) That is already happening in certain of the areas but what we need are standards of practice.

(Supervisory Clinician) I haven't been getting anywhere with the problem-oriented records. In order to put these into operation, I feel that they would have to be standardized across the different service areas.

(Director) I feel that [names of certain supervisory clinicians] are doing good jobs, and that the way that we can improve our quality is by recruiting people who already have experience.

(Evaluator) There should be clear guidelines and regulations concerning what is expected, particularly with respect to treatment records.

(Director) It is hard to put down guidelines in terms of good treatment. For example, I can keep good records but make it perfectly clear to the patient that I don't care what he thinks, and still get him out of the office by saying the right things.

(Evaluator) Or you could also have poor records and poor treatment or poor records and good treatment. . . .

Whatever the reason, the problem-oriented record system apparently failed to take hold in the two centers where it was introduced. Part of the failure was the result of the fact that only a few persons in each center were truly interested in establishing

the system. Despite their formal powers,⁴⁵ these persons ran into strong opposition from lower level persons who felt that the system was a burden on them:

(Director) The way that it was implemented here was that the clinical director tried to influence the other physicians to undertake the system. But they weren't keen on it or didn't understand it. When it comes to dictating the patient's history and the paperwork, the nurses are probably the ones doing it. And so the clinical director would dictate the problems and discuss the solutions that he wanted done. But the nurses were resistant to this. They had been used to looking at the record and seeing that he wanted the patient to have this degree of privileges, for example, either to go to recreation or not to go. . . . And then one day the nurse goes down there and the clinician would tell her to discharge the patient which she would. But here, with the problem-oriented system, all of a sudden, you have a psychiatrist saying, "Here is the ball, you run with it. I made the game-plan. . . ." The nurses react such as follows: "How do you, the psychiatrist, know from talking for thirty minutes with him what he wants to do? It is easy to say to have him quit smoking, but here he is saying that if I don't give him a cigarette that he will kill me."

Thus, the lower level personnel in the organization feel that this record system places a burden on them. The difficulty of implementing this evaluative tool is revealed in the following exchanges among a director, psychiatrist, and evaluator concerning how to deal with the new record-keeping system.

(Psychiatrist) How would this be for a problem-oriented model: (1) Problem: frequent running away from school, (2) Goal: to help him remain in school, and (3) Plan: family therapy?

(Evaluator) That isn't specific enough. The goal should be more specific so that we can evaluate whether or not it was achieved, for example, decrease by 50 percent the amount of running away.

⁴⁵A director and clinical head were the persons who attempted to implement the system in the two organizations.

(Psychiatrist) When I can get the paraprofessionals to say that the problem is running away from school rather than adolescent rebellion, I have achieved something.

(Director) Isn't there some thing or some way for the data to be computerized so that we can get sequential records for each patient when he is seen?

(Psychiatrist) That is the point we want to get to, but first you have to teach the people how to collect the data.

(Director) Then why can't you have the computer yell out when this particular item isn't filled in?

(Psychiatrist) That would simply make them go for shallow answers and make it mechanical. You would have to audit the records. They would need a professor at their elbow to fill these out.

Here we see the importance of two of the linkages already mentioned-- the problem of teaching the method and the problem of having the practitioners take it seriously enough to use it. In the centers where it was introduced, the problem-oriented system was gradually abandoned. The reasons included indifference on the part of staff and the more pressing demands of rising client loads which would only have been aggravated by a more complicated form of record-keeping.

Other Evaluations

In addition to the kinds of evaluations that we have already examined, there were other forms of evaluation being carried out. However, they were either limited to one center or failed to meet the criteria established for scientific evaluation. One of the more

interesting of these other forms of evaluation is called "process analysis." It was initiated at one of the centers. Most evaluations attempt to measure the results of therapy but process analysis focuses on the interaction between therapist and client while the therapy is being carried out. At repeated intervals, the client and therapist fill out questionnaires concerning their subjective feelings and perceptions concerning the other person. Some evidence exists that the degree of empathy that exists between the client and therapist is a major factor in determining whether the outcome is successful.⁴⁶ In this particular case, the evaluator found some interesting patterns, for example, that some therapists do better at certain times of the day. However, other than providing some interesting feedback to the clinicians, this evaluation failed to produce any substantive change in the Center's operations.⁴⁷

There were some evaluations which focused on specific programs of particular organizations. An example of this kind of evaluation is the following which concerned a program for emotionally disturbed children:

⁴⁶See Jerome D. Frank, "The Bewildering World of Psychotherapy," Journal of Social Issues, Vol. 28, No. 4 (1972), pp. 28-43.

⁴⁷However, several persons, including the evaluator, left the organization before this evaluation had been established for very long.

(Evaluator) We have a series of tests given to them. One is a social adaptation test that is given to the classroom teacher from the regular classroom from which they come. Then it is given to the classroom teacher here and they are also given a test for academic test and. . . for social adaptability. If this works out, we can use it as an actual instrument to decide, or aid in making the decision, about when these children should return to the school. . . .

While this evaluation has potential implications for the quality of the program, there were no plans to draw such conclusions but rather to focus on decisions that concerned the students.

Finally, there were a number of miscellaneous evaluations which bordered on or clearly did not meet, the criteria necessary to be called scientific evaluations. These include the following: (1) meetings at which the treatment of a few, selected cases was discussed by clinicians in a program; (2) performance ratings by supervisory personnel of the organization concerning the therapists under their control.

The use of a review committee or general meetings to review the practices and effectiveness of therapy is a common practice in these organizations. When such meetings effectively combine the judgments of qualified observers, such judgments are likely to be more reliable than the judgments of a single observer.⁴⁸ Such

⁴⁸For a discussion of the problems of rating systems, whether carried out by a group or an individual supervisor, see Lee J. Cronbach, Essentials of Psychological Testing (3rd ed.; New York: Harper and Row, 1970), pp. 571-607.

meetings often combine more subjective forms of judgment with certain selected statistical data. A director describes the nature of one such meeting in a crisis intervention program:

(Director) Each week a meeting is held to discuss cases, review procedures, and provide inservice training in order to improve the total program. Each week three active cases are picked for critical review. In addition, four to twenty-four crisis calls are critically evaluated and reviewed. During the year, at various times, statistical data is collected to describe the number of cases, referral sources, reasons for referrals, and so forth.

It is likely that in such meetings the value of the criteria used depends to a great degree on the particular individuals heading the programs and leading the discussions. Checking for the validity and reliability of the judgments expressed is usually beyond the resources of those involved in the discussions, even if they felt the need to do so.

Rating by a superior is one of the most prevalent forms of evaluation in any type of organization. In the organizations under study, there is usually a checklist of items on which the therapist is rated. A clinician at one of the centers describes one such list:

(Supervisory Clinician) Quality-wise, of course, each clinician is evaluated by five areas that we look at: (1) forms, scheduling, and this kind of thing, (2) ability to work with other clinicians, (3) the diagnostic astuteness of the particular person, and, if you are going to separate diagnosis from treatment, (4) their actual treatment ability.

The validity and reliability of such rating systems is problematic, being affected by personal relationships, "halo effects," rumors,

and many other nonscientific factors.⁴⁹

Summary

Each major evaluative technique used by these organizations has been analyzed with respect to the scope of the activities covered by the evaluation, the degree to which it is accomplishment-oriented, and the extent to which it has had a substantive impact on the operations of these organizations.

Goal attainment scaling and problem-oriented records both have a potentially broad scope because they can be applied to nearly any service offered by the organization. Consumer satisfaction surveys and needs assessment surveys appear generally to have too broad a scope to be able to provide much information that can lead to specific recommendations. None of these evaluations covered, or was even related to, important decision areas such as budgetary and personnel decisions.

The consumer satisfaction surveys focused upon an important goal of the satisfaction of the clientele. However, it was found that these surveys did not provide information that discriminates clearly between good and poor services. The goal attainment forms of evaluation have a sharper focus because they measure the extent to which clients are perceived to have attained specific goals.

⁴⁹Also, a tendency to give only high ratings usually emerges in such a system. See Peter M. Blau, The Dynamics of Bureaucracy, p. 221.

Psychiatric epidemiological surveys also focus upon an important goal of these organizations--the decrease in the prevalence of mental illness in the areas served by the organizations. However, these surveys provide information that is far from clear concerning the quality and effectiveness of the services offered by the organization. Also, it generally takes an extremely long period of time before any feedback is derived from these surveys. Problem-oriented records are directed at a more technique-oriented goal of these organizations, the keeping of good records. As a consequence, the expected impact of keeping good records depends upon several assumptions concerning the relationship between such records and the ultimate effectiveness of the treatment.

Distinguished by their absence are evaluations which focus on the effect these organizations have on decreasing the prevalence of behaviors such as alcoholism and drug addiction. No attempt was made to use controls in the evaluation, either through the use of experimental or quasi-experimental designs. Also, none of these evaluations focuses upon the success of programs as opposed to individual therapists. The scores obtained from the goal attainment method can be aggregated to form a score for an entire program but the focus of the evaluation remains the work of the individual therapist.

In regard to the impact of these evaluations, certain types of

evaluations such as goal attainment evaluation provided feedback to therapists. Whether this added feedback actually led to increased quality in the services offered by the organizations was not tested. Psychiatric epidemiological surveys were used to help determine the location of some new services.

Aside from the above examples, these forms of evaluation appear to have had strikingly little substantive effect on the operations of these organizations.⁵⁰ Indeed, many of the directors of these organizations were undertaking evaluations such as consumer satisfaction surveys and epidemiological surveys from which they expected to obtain little, if any, useful information.⁵¹ They expected these evaluations to confirm only what they already knew.

All forms of evaluations studied consumed significant amounts of resources such as the time of the clinical staff. Thus, because of the time spent in carrying out psychiatric epidemiological surveys or filling out goal attainment forms, the clinicians may be unable to see as many clients.

⁵⁰These conclusions again must be qualified for the following reasons: (1) most evaluations had not been in existence for a great period of time; (2) the evidence is based on interviews and participant observation.

⁵¹The author is referring to internal organizational uses only. In later chapters, other, externally-oriented functions of these evaluations are examined.

The general lack of much impact would tend to support Wildavsky's contention that organizations cannot evaluate themselves critically. However, this conclusion is tentative and leaves unanswered several important questions that need to be explored in future chapters, including the following: (1) Is the lack of impact of these evaluations the result of resistance of the therapists to these methods of formal evaluation? (2) How are decisions made if they are not decided on the basis of formal, scientific evaluations? These and other issues will be explored in the next chapter, in which attitudes towards evaluation are examined.

CHAPTER III

ATTITUDES TOWARD EVALUATION

The purpose of this chapter is to examine attitudes toward evaluation held by personnel of the organizations under study. In particular, the attitudes of three groups of personnel, whose acceptance of formal evaluation is critical to its success, are examined: clinicians, directors, and evaluators.

In Chapter II, it was concluded that formal evaluation has brought about little change in the operations of the mental health organizations in which it has been introduced.¹ In Chapter I, three problem areas of organizational theory which provide explanations as to why evaluation is likely to have little impact were introduced:

- (1) The relationship between the natural and artificial systems of an organization: the development of a formalized evaluation system may be viewed as an infringement on the natural system elements of the organization.

- (2) The technology of evaluation: resistance to evaluation may be the result of the lack of development of the technology of evaluation and result in skepticism among the personnel of the organizations toward the evaluation.

¹As noted in Chapter II, this conclusion is qualified on the basis of the particular time period when these fourteen organizations were studied.

(3) The struggle for survival: the necessity to put survival needs first may block the evaluation from having any significant impact on the organization.

Through the examination of the attitudes toward evaluation, the importance of the first two of the above factors is examined in regard to their being obstacles to the successful implementation of formal evaluation. In other words, can the apparent lack of impact of evaluation be attributed to the clinicians' anxiety and resistance to the introduction of formal evaluation? Is the lack of impact of evaluation the result of skepticism concerning the validity and reliability of the technology of formal evaluation?

To aid in our analysis of attitudes toward formal evaluation, attitudes toward informal and openly subjective types of evaluation are also studied. Likewise, comparisons are made between the use of information derived from formal and informal types of evaluation in the decision making of the organizations under study.

Attitudes Toward Formal Evaluation

The exploration of the attitudes toward evaluation is based a combination of participant observation, interviews, and questionnaires. The questionnaire consists of twenty-eight questions designed to explore significant issues relevant to analyzing the attitudes toward formal evaluation held by clinicians, directors, and evaluators within these fourteen organizations. The items included in the

questionnaire were selected as relevant based on a search of the literature, five months of participant observation, and interviews with evaluators in different organizations.² The total number of persons included in the questionnaire survey is small. Non-random methods of selection were used due to the limitations of time, access, and money in the selection of the respondents. Thus, inferences beyond the particular group of persons sampled are problematical.³ The questionnaire is intended to serve only as an approximation of the attitudes of the individuals sampled and a supplement to the information derived from participant observation

²Thus, the questionnaire was not constructed until after five months of participant observation had already been carried out. A preliminary form of the questionnaire was given to the evaluators who offered suggestions that were incorporated into the final form. It should be noted that the instructions to the questionnaire specified that the questions referred specifically to formal evaluation carried out by an evaluator and his staff.

³Questionnaires were given to all directors and evaluators within the fourteen organizations at the time of the study. In two organizations, there were two persons identifiable as directors. In one case, directorial responsibilities were divided between a clinical and administrative director. In another case, there was a change of directors during the course of the study. Questionnaires were given to clinicians on the basis of access in each of the organizations. Thus, there may be a bias in the responses obtained. However, the questionnaires are intended to serve (as is noted above) only as a supplementary form of information and the data derived from them were generally supported by interviews and participant observation carried out.

and interviews.⁴

Natural System Elements

The natural system of an organization consists of unprogrammed elements such as personal friendships, cliques, and informal group values.⁵ Decisions concerning such personal matters as job promotion and security are determined largely by informal and subjective judgments which are closely involved with the elements that compose the natural system. The use of formal evaluation carried out by an evaluator is likely to be viewed as an infringement upon the elements of the natural system of the organization if the informal system is a legitimate obstacle to the successful implementation of formal evaluation.

To explore the importance of these natural system elements through the use of questionnaires, it was hypothesized that clinicians would favor evaluations that were highly generalized and non-threatening but would oppose evaluations that concerned matters of more direct importance to themselves such as job promotion and

⁴See the appendix for a complete listing of the questions asked. The first and second halves of the questionnaire are intended to be equivalent measures of attitudes toward evaluation. An index of reliability of the questionnaire, computed according to Rulon's formula, was calculated to be .97 based on the sixty-three completed questionnaires (of the original eighty-four sent out). See J. P. Guilford, Psychometric Methods (New York: McGraw-Hill Book Company, 1954), pp. 385-386.

⁵Thus, the term "natural system" is an analytical concept.

security--matters that are now mainly determined by informal judgments.

Responses to the items in Tables 3.1 through 3.9 tend to confirm the thesis that clinicians support highly general evaluations but are much less enthusiastic about evaluations that concern matters of personal importance to them. Tables 3.1 and 3.2 reveal that approximately 90 percent or more of the clinicians support evaluation for the general purposes of providing feedback to the clinical staff and for carrying out an overall evaluation of the organization. Tables 3.3, 3.4, and 3.5 reveal strong support also for the concept of program evaluation with well over 80 percent of the clinicians favoring evaluation for this purpose in each case.

However, support drops sharply for formal evaluation in the items relating to evaluation of individual performances in Tables 3.6, 3.7, 3.8, and 3.9. More specifically, the items in Tables 3.6 and 3.7 concerning the use of evaluation to judge whether a member of the organization is doing a good job receive approximately 60 and 50 percent support respectively from clinicians. The two items concerning the use of formal evaluation to determine who should be promoted or fired receive only 34 and 21 percent support respectively.⁶

⁶The repetitiveness of many of the questions results from the use of the split-half method of measuring reliability. In this method, two approximately equal halves of a questionnaire are constructed.

TABLE 3.1

FEEDBACK

Evaluation can and should be used to furnish feedback for the clinical staff.

Response	Percentage of Clinicians	Percentage of Directors	Percentage of Evaluators
Strongly Agree	73.7 (28)	75.0 (12)	100 (9)
Agree	23.7 (9)	25.0 (4)	---
Undecided	2.6 (1)	---	---
Disagree	---	---	---
Strongly Disagree	---	---	---

TABLE 3.2

OVERALL ORGANIZATION

Evaluation can and should be used to determine whether or not the overall organization is performing well.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	36.8 (14)	43.8 (7)	66.7 (6)
Agree	52.6 (20)	43.8 (7)	33.3 (3)
Undecided	10.5 (4)	6.3 (1)	---
Disagree	---	6.3 (1)	---
Strongly Disagree	---	---	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 3.3
PROGRAM EVALUATION: #1

Evaluation can and should be used to determine the impact of the organization's programs on the community.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	28.9 (11)	18.8 (3)	55.6 (5)
Agree	63.2 (24)	56.3 (9)	44.4 (4)
Undecided	5.3 (2)	18.8 (3)	---
Disagree	2.6 (1)	6.3 (1)	---
Strongly Disagree	---	---	---

*Sum of percentage figures is greater than 100 percent because of rounding.

TABLE 3.4
PROGRAM EVALUATION: #2

Evaluation can and should be used to determine which service programs, if any, are performing poorly.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	28.9 (11)	25.0 (4)	22.2 (2)
Agree	57.9 (22)	50.0 (8)	77.8 (7)
Undecided	10.5 (4)	6.3 (1)	---
Disagree	2.6 (1)	18.8 (3)	---
Strongly Disagree	---	---	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 3.5
PROGRAM EVALUATION: #3

Evaluation can and should be used to determine whether individual mental health programs are successful or not.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	39.5 (15)	43.8 (7)	88.9 (8)
Agree	47.4 (18)	50.0 (8)	11.1 (1)
Undecided	13.2 (5)	---	---
Disagree	---	6.3 (1)	---
Strongly Disagree	---	---	---

*Sum of percentage figures is greater than 100 percent because of rounding.

TABLE 3.6
EVALUATION OF INDIVIDUAL CLINICIANS: #1

Evaluation can and should be used to determine whether or not individual clinical staff members are performing their jobs well.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	15.8 (6)	18.8 (3)	11.1 (1)
Agree	47.4 (18)	50.0 (8)	22.2 (2)
Undecided	10.5 (4)	12.5 (2)	44.4 (4)
Disagree	26.3 (10)	18.8 (3)	22.2 (2)
Strongly Disagree	---	---	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 3.7
EVALUATION OF INDIVIDUAL CLINICIANS: #2

Evaluation is neither valid nor reliable enough to be used to determine who is doing a good job.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	---	6.3 (1)	---
Agree	26.3 (10)	31.3 (5)	33.3 (3)
Undecided	23.7 (9)	31.3 (5)	---
Disagree	47.4 (18)	18.8 (3)	66.7 (6)
Strongly Disagree	2.6 (1)	12.5 (2)	---

*Sum of percentage figures is greater than 100 percent because of rounding.

TABLE 3.8
EVALUATION OF INDIVIDUAL CLINICIANS: #3

Evaluation is currently neither valid nor reliable enough to be used to determine who should be promoted within the organization.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	15.8 (6)	25.0 (4)	22.2 (2)
Agree	36.8 (14)	12.5 (2)	22.2 (2)
Undecided	13.2 (5)	43.8 (7)	22.2 (2)
Disagree	34.2 (13)	12.5 (2)	33.3 (3)
Strongly Disagree	---	6.3 (1)	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 3.9
EVALUATION OF INDIVIDUAL CLINICIANS: #4

Evaluation can and should be used to determine who should be fired from their jobs.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	---	---	---
Agree	21.1 (8)	12.5 (2)	---
Undecided	28.9 (11)	31.3 (5)	33.3 (3)
Disagree	34.2 (13)	43.8 (7)	22.2 (2)
Strongly Disagree	15.8 (6)	12.5 (2)	44.4 (4)

*Sum of percentage figures is unequal to 100 percent because of founding.

In short, the thesis that clinicians favor generalized, formal evaluations more than formal evaluations which focus on individuals is supported by the above evidence. The data offer support for the view that the elements composing the natural system present an obstacle to formal evaluation. In other words, the relatively low support found for the use of formal evaluation as a means of evaluating individuals can be interpreted as indicating that clinicians wish to keep such evaluation more informal and personalized.

Two qualifications must be made concerning this conclusion. First, despite the fact that support for individualized uses of formal

evaluation is lower than more general uses of evaluations, fairly large percentages of the clinicians in the sample, 34 percent and 21 percent respectively, support the use of formal evaluation for even the most threatening of uses such as promotion and firing. Based on participant observation and interviews, the reason for the support for formal evaluation to be used for such functions can be explained by the fact that not all clinicians are happy with the way in which individual performances are now judged.⁷ One evaluator described a situation in which a clinician felt "put down" by the judgments of his superiors and other staff in the organization. This situation led the clinician to ask to be evaluated by the use of formal, goal-attainment scaling evaluation:

(Evaluator) I don't know why but several times [name of the clinician] was put down. People were saying that he simply wasn't doing anything worthwhile. So, he said, "Alright, I want to be evaluated. Come over and evaluate us." It was like, "We're open to anything."

Thus, some clinicians support formal evaluation for even the most threatening of uses.

A second qualification is that the responses of the clinicians need not be interpreted simply as a preference for purely subjective

⁷The preference of French workers for avoiding situations in which their supervisors have discretionary power over them has been pointed out by Michel Crozier in The Bureaucratic Phenomenon (Chicago: University of Chicago Press, 1964).

evaluation. Clinicians most strongly support evaluations which give them something in return such as feedback. Likewise, they offered greatest opposition to the use of evaluation for the most threatening decision of all--the decision to fire someone from a job. Thus, the responses of the clinicians may be interpreted within the framework of a simple decision making model: support evaluations that do not threaten your own position and that offer you potentially positive rewards such as feedback.

It might be expected that directors would be more favorable toward the use of formal evaluation to evaluate individual clinicians. They are at the top of the formal authority structure and would have less reason to be anxious about the use of formal evaluation for this purpose. However, Tables 3.1 through 3.9 generally show that the responses of the directors parallel those of the clinicians. The directors are much more favorable towards the use of formal evaluation for general purposes than for the evaluation of individual clinicians.

Drawing on interviews and participant observation, the failure of the directors to be any more favorable than the clinicians toward the use of evaluation for this purpose can be due to two reasons. First, many of the directors retain a strong identification with the clinical role and the point of view of the individual clinician. Secondly, while they are not likely to be personally threatened by such evaluation, nevertheless the formal evaluation would take away

some of their power. Their informal judgments would no longer be the sole way of evaluating the personnel under their control.

The responses of the evaluators provide more substantial evidence for the validity of the natural system as a constraint on evaluation. In Tables 3.1 through 3.5, the evaluators demonstrate almost total support for evaluation which deals with the overall organization, programs, and the purpose of providing feedback to the clinicians. However, support for the use of formal evaluation to evaluate individual performances drops off sharply among the evaluators in Tables 3.6 through 3.9. In particular, most evaluators do not favor the use of formal evaluation for the determination of the promotion or firing of individuals. The responses of the evaluators do not make much sense if interpreted within the framework of a short-run power maximization model of man. If the evaluator could use formal evaluation to evaluate the individual performances of organizational members, he would immediately become a very powerful figure in the organization.

Yet, interviews and participant observation demonstrated that evaluators generally prefer a much more innocuous form of evaluation. They anticipate great anxiety, fear, and general resistance to any attempt to use formal evaluation to evaluate individual performances. The author asked one evaluator if he distinguished between the evaluation of programs and the evaluation

of individuals and received the following response:

(Evaluator) Yes, program evaluation is the basic unit here. We will take a program like the outpatient clinic. . . . Measuring the success of the individual therapists within that clinic is possible using similar methodologies. But I don't think I would take the analysis down that way unless somebody asked me. . . .

The evaluator was then asked what advantages he saw in program evaluation over the evaluation of individuals:

(Evaluator) Well, it is less threatening. . . .

Another evaluator expressed himself in a similar manner concerning his preference for program evaluation:

(Evaluator) Well, my personal preference is for program evaluation but, unfortunately, if a program flops, it is pretty obvious that somebody is at fault there. I would rather not have to get down to evaluating specific people. I think that is why I have encountered so little resistance because I have made the fact clear that I would not be evaluating people, at least for the time being, if at all. . . .

In short, most evaluators do not want to undertake evaluations that can be viewed as threatening by persons they have to work with daily and whose cooperation they need to implement even non-threatening evaluations.⁸

However, there is an irony concerning the preference for more

⁸Some evaluators indicated that they hoped to have more of an impact in the future. This point is discussed further in a later chapter.

generalized evaluations such as programs evaluation. In Chapter II, it was discussed that current evaluation techniques either focus on the performance of the individual therapist or are too broad to draw implications concerning the performance of programs. Many important choices among types of programs have to be made, such as whether to emphasize direct or indirect services, short or long term therapy, and group or individual therapy. But the evaluative techniques currently being used by these organizations do not have the capability of evaluating which types of programs are more effective.

Interviews and participant observation indicated that there was ambivalence concerning the proper focus of evaluation. Most clinicians, evaluators, and directors preferred the more generalized evaluations such as program evaluation. However, directors admit in the following responses that the successful performance of the individual clinician is a key to the success of the overall program:

(Director #1) I don't look at the individual therapist. I look at what you do with your program. But I guess that you are evaluating all of the therapy that is taking place in the program, but I have never thought of it in terms of evaluating the individual therapists--which may be a natural step but I haven't gotten there.

(Director #2) Sure, the real focus of the evaluation should be the interaction between the client and therapist. That is the program, generally. The key factor is the quality of the therapist.

In the following interview, a dispute concerning the proper

focus of evaluation occurred between a clinical psychologist and a psychiatric social worker, the former preferring program evaluation and the latter, evaluation of individuals:

(Clinical Psychologist) Programs are a lot more solid to deal with.

(Social Worker) Much more what?

(Clinical Psychologist) Concrete to deal with than therapists.

(Social Worker) I would totally disagree with you. I would say that it was the other way around because the only thing that I know how to evaluate are personal performances which are easy for me to evaluate.

(Clinical Psychologist) Subjectively.

(Social Worker) Uh, in part.

(Clinical Psychologist) I can make a subjective evaluation of psychologists in regard to my confidence in them--all in my head.

(Social Worker) So far as evaluating. . . I don't know that I know of anything where one can consciously set up a method of evaluating programs.

(Clinical Psychologist) I think it might be easier to set up a set of objective criteria, for example, to compare the performance of social workers and psychologists with the rating scale that I have in mind.

Thus, there exists ambivalence concerning the proper focus of formal evaluations. Despite the fact that popular methods of formal evaluation, such as goal attainment scaling, are most clearly directed at evaluating individual performances, interviews and questionnaire data demonstrate that most clinicians and evaluators

favor program evaluations over evaluations aimed at individuals.

The evaluators are deliberately trying to avoid threatening the clinical staff by their evaluations. Interviews indicate that they anticipated resistance from the elements of the natural system of the organizations if they attempted to implement threatening evaluations. At a meeting attended by both evaluators and state officials bent on encouraging evaluation, there was a disagreement between whether to go slowly and avoid threatening evaluations or to begin by evaluating individual clinicians:

(State Official) I can't imagine pressure being put on the therapist. I think that you will find that most anxiety is a problem before evaluation is implemented--if it isn't used to club them.

(Evaluator #1) I found the same thing: resistance before the implementation of evaluation. . . .

(Evaluator #2) But I was placed on a probationary period for my first few months at the . . . Center and I don't see why evaluation can't be used to evaluate the staff.

(State Official) It is a good idea. But it is a problem of not threatening or frightening people too much. You have to use tact. If it is done in a cooperative way. . . .

Due to the fact that most evaluators prefer to introduce formal evaluation in a non-threatening way, the influence of the natural system elements of the organization is more indirect than direct. Although active resistance from the informal elements did not emerge, most evaluators had clearly anticipated such resistance, which is one of the major reasons why they favored general evaluations such as program evaluation.

The Technology of Evaluation

How important is skepticism about the technology of formal evaluation as an obstacle to its implementation? One of the most commonly stated arguments of those who oppose formal evaluation is the contention that it is impossible to quantitatively measure the crucial aspects of services to clients. An item which formally stated this argument was included in the questionnaire. Data in Table 3.10 show that slightly over 30 percent of the clinicians in the sample agree with this argument but that over 50 percent of the clinicians reject it.

TABLE 3.10
QUANTITATIVE MEASURES OF DIRECT SERVICES

It is impossible to measure quantitatively the most important effects of mental health direct services.			
Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	7.9 (3)	---	---
Agree	23.7 (9)	37.5 (6)	---
Undecided	15.8 (6)	18.8 (3)	11.1 (1)
Disagree	44.7 (17)	18.8 (3)	66.7 (6)
Strongly Disagree	7.9 (3)	25.0 (4)	22.2 (2)

*Sum of percentage figures is greater than 100 percent because of rounding.

Clinicians, evaluators, and directors were all asked to rank the most important obstacles to the successful implementation of a formal evaluation. An index of the relative importance of each obstacle was constructed as described in Table 3.11. The data in this table reveal that, among clinicians, the lack of reliability and validity of current evaluative techniques was ranked as the second most important obstacle after the lack of resources of time, money and staff. It was noted previously that clinicians demonstrated strong support for generalized forms of evaluation. However, their responses to the item in Table 3.11 show that they hold substantial reservations about the technology of formal evaluation. The attitudes of many of the clinicians spoken with are similar to those expressed by the following clinician:

(Clinician) Well, I am not too impressed with the evaluation methodologies. But I think that they are something that can be lived with. By living with them, I mean that you know the pitfalls of the methods.

In an interview with two therapists, one argued that the current evaluation technology was insufficient. The other therapist tended to agree but argued that the lack of evaluation technology was the result of the low priority given to it:

(Clinical Psychologist) I think that it [formal evaluation] could be done. . . that one of the reasons that the technology isn't better is because we haven't been committed to it. But given the time and money it would take, who is going to pay for it and where is the payoff from it?

TABLE 3.11
OBSTACLES TO EVALUATION

Please rank the following factors in what you regard to be their order of importance as obstacles to evaluation. Evaluation here refers specifically to formal evaluation carried out by an evaluator and his staff.

Obstacle Number:

- 1 The lack of reliability and validity of the current evaluation techniques.
- 2 Anxiety on the part of the direct service staff as to how evaluation is to be used.
- 3 The belief of professionals that they should evaluate themselves and do not need formal evaluation by an evaluator.
- 4 The lack of skills necessary in the evaluation staff to carry out a valid and reliable evaluation.
- 5 The lack of resources of time, money, and staff for the researchers to carry out valid and reliable evaluations.

The following index of "importance" was formed by scoring five points for each time that an obstacle was rated as being the most important, four points for the next most important, etc.

Clinicians		Directors		Evaluators	
Number	Points	Number	Points	Number	Points
5	139	5	55	5	39
1	134	1	49	1	27
2	107	4	43	2	27
4	103	2	38	3	24
3	82	3	34	4	23

No clinician interviewed stated that he was "against" formal evaluation. However, many clearly hold reservations about the validity of evaluation technology. They see the lack of resources to develop an adequate technology of formal evaluation as an even more important obstacle.

Evaluators themselves hold reservations about the status of the technology of formal evaluation. Table 3.11 shows that they ranked the unreliability of evaluation technology as second only to the lack of resources as an obstacle to the successful implementation of formal evaluation. Because of the non-threatening nature of most of the evaluations, the evaluators had not been directly challenged as to the validity of formal evaluation. However, when the author asked one evaluator how he thought that the staff would react to a negative evaluation, he described what he thought would be the most likely reaction as follows:

(Evaluator) Oh, I think that the first thing they will say is that it is invalid and that the methodology is all screwed up, that it doesn't show anything. Or, they will point to the techniques and the methodology and the way the evaluation is done to discredit it.

The only negative, personal evaluation observed by the author was when a particular evaluator kept time logs on the clinical staff concerning how they spent their time. He came up with surprisingly low figures for the amount of time the clinicians spent in direct services. Some clinicians did challenge his figures as being invalid.

The following director explains why he feels that his organization should not be directly compared to another mental health organization in an adjacent county:

(Director) To judge the effectiveness of a community program, let's take for example reducing the number of admissions to a state mental hospital as a measure of effectiveness, I think that that is a simple-minded measure of . . . effectiveness. Take, for example, [name of a mental health organization in an adjacent county]. It has federal funds for staffing and can take care of people better locally because they have the money to do it. To compare our admission rate with a community that is better able financially to take care of this kind of patient is an unfair comparison. And it just scares me that the people juggling these figures don't know the differences in the communities.

At the program level, one supervisory clinician in a rural area argued that figures such as those concerning time spent in delivering direct service did not have the same meaning as they did in a more urbanized area:

(Supervisory Clinician) You could compare this area with other areas. Sure, for example, you could tell whether or not the patients are attaining their goals as well as they are in other areas. O.K., but what decisions do you make from this? I think that you have to look at what the constraints are. Here, for example, it is very hard for patients to get in to see you which is why I didn't feel bad about spending only 15 percent of my time in direct service.

Some clinicians reject even the most rigorous of evaluation methodologies such as experimental models:

(Clinician) I can only give you my own biased opinion and that is, that in my concept of a human being, there are so many complications, so many things that can affect what we do, that I don't see how you can have a control that even half-way covers a few of these factors. So, no, I don't see any purpose in having controls at all.

The author asked the same clinician if she thought that formal evaluation could be used to compare the benefits of different programs:

(Clinician) Nobody seems to have devised any particular methodology of any kind that does any good. So how in the world can they decide whether this kind of therapy does better than that kind?

Nevertheless, the clinician mentioned above rated the performance of the evaluator in the organization quite favorably because the latter had helped her write grant proposals and had not attempted to make invidious comparisons between programs.

To summarize, the attitudes held by clinicians and directors in the organization are ambiguous. They generally support highly generalized evaluations but retain reservations about the validity of current evaluative techniques. There was little evidence that skepticism concerning evaluative techniques has led to direct opposition to the implementation of any evaluation. However, the lack of such resistance was the consequence of the non-threatening nature of current evaluations more than the result of confidence in evaluation technology. Many clinicians and directors feel strongly that no formal evaluation can determine the comparative effectiveness of organizations and programs. Most clinicians and directors believe that the particular constraints of their programs and organizations must be understood before any evaluative judgments are made.

Thus, it would appear that weaknesses in methodologies of evaluation and comparisons based on formal evaluations can always be found. As a consequence, clinicians and directors are likely to be able to find a basis to reject an evaluation which disagrees with their basic beliefs. Thus methodological weaknesses are likely to turn the debates raised by evaluations into a struggle among individuals with different value systems or subjective preferences.⁹ When this occurs, the outcome is more likely to be determined by the relative power held by the participants in such debates rather than by the force of evidence from scientific evaluations. Despite the further development of the technology of mental health evaluation, this same phenomenon of technical evaluative issues being reduced to questions of values and power is likely to occur.

Alternative Forms of Evaluation

In the first section of this chapter, the attitudes of key groups of personnel in these organizations were examined with particular focus given to the degree of anxiety aroused by formal evaluation and skepticism concerning its technology. However, it has been

⁹Thus James Q. Wilson argues that evaluators will find policy interventions effective or non-effective depending on whether the researchers evaluating the impact support or oppose the policy. See James Q. Wilson, "On Pettigrew and Armor: An Afterword," The Public Interest, No. 30 (Winter, 1973), pp. 132-134. See also the discussion concerning this point by Walter Williams, Social Policy Research and Analysis (New York: American Elsevier, 1971), p. 104 and p. 123.

emphasized that formalized evaluations did not play a significant role in organizations decision making, whether important or routine decisions were involved.

Nevertheless, decisions are made daily which require evaluative judgments in choosing between alternative courses of action. Examples of the kinds of decisions being referred to include such issues as determining who is doing a good job in the organization, which programs should receive a higher percentage of revenues, and how much emphasis should be placed on various kinds of programs. Since formal evaluation did not have much, if any, impact on the decision making process, the kinds of evaluation actually used to reach such decisions are examined here.

A primary form of evaluation is the openly subjective and intuitive type of judgment used by many clinicians and directors to evaluate the work of their subordinates or colleagues. While it may be supplemented by other data, the directors and clinicians interviewed were quite frank about the subjective basis of most of their judgments. Moreover, many of these directors and clinicians feel that the subjective form of evaluation is quite valid as revealed in the following comments:

(Director #1) I know for a fact that there are some kinds of therapists that work fantastically with one kind of patient but blow it with another kind. Maybe I am being defensive, I don't know, but I do think that the gut feeling type of evaluation that therapists do of one another has an

awful lot of validity, and I wonder if we subjected them to a microscopic kind of scrutiny, that that wouldn't kill something that goes on between therapist and the patient.

(Director #2) I myself don't feel that the state of the art of evaluation is very well developed. Then, again, you know, when you work with people, you know (although I know that I can't prove it with any kind of validity) what the place does. I know what the weak points are and I know what the strengths are. And, subjectively, I know pretty much who the strong therapists are, and who the weak ones are.

(Supervisory Clinician) A lot of people would disagree with me on this but I think that the quality of a person's treatment can be easily evaluated. You can watch the way they handle themselves as they progress along the line from admittance to discharge. I have a conceptualization of the way that I think that treatment should be and I tell or advise others. . . .

As would be expected, evaluators took issue with the argument that such subjective evaluations can be valid:

(Evaluator #1) I think that any evaluation is going to be subjective. But for an individual to say that he can subjectively but validly evaluate--I think that is bullshit. I think we wind up with degrees of subjectivity. . . .

(Evaluator #2) There are people around here, of course, that I don't like, but that does not mean that they are not good clinicians, or that they are not good in the position that they are in. So I guess that I would tend to rely more on a formal type of evaluation.

Several clinicians and some directors agree that the validity of these subjective evaluations was questionable. One director argues that such judgments are self-reinforcing:

(Director) If I have an idea that massage therapy or individual therapy is a good thing, and I do it and I get paid for it, then with the reinforcement schedule that I have set up for myself, I can convince myself that such and such method is a really good thing. You just look at these people and they are better period. That is the clinical impression.

A clinician argues that subjective evaluations are particularly difficult when the "evaluator" and the person being evaluated disagree on values or are separated by cultural differences:

(Supervisory Clinician) Subjective evaluation is very tricky--that is doing things by instincts. We love to talk. That is one of the most enjoyable things that people do--talking to one another about somebody else. But the whole social service structure is basically involved in subjective evaluation. . . Where you really get in trouble is when you have cross-cultural differences.

However, despite the doubts which many clinicians and directors have about intuitive evaluations, there was general agreement among those interviewed that many day-by-day decisions are made on this basis. Moreover, the confident manner in which such intuitive evaluations are used contrasts sharply with the hesitant manner in which formalized evaluations are employed in these same organizations.

Most decision makers in these organizations do seek out additional information when it is available to supplement their subjective impressions. The following director describes how evaluators had collected data which contradicted his impressions about the comparison between the effectiveness of two different services. However, he concludes that he is right about which is the better service despite the formal data presented by the evaluators:

(Director) The evaluators have given me something that shows, for instance, that one of the services that we

have at the county hospital has an average of 12.5 days of hospitalization which is worse than the other which has a 10 days average. But the one with 12.5 average has only 24.6 percent going to the State Hospital whereas the one with a 10 days average has 41.5 percent going. Well, this might be significant but there are so many other things involved in this that it is a little difficult to make that conclusion. The one with a 10 day average I thought would be the longer one. And the one that is longer, 12.5 days, which is a little bit longer than we are shooting for but which I feel is the better service. . . .

A supervisory clinician describes how he uses a wide variety of data to evaluate the therapists under his direction with a combination of tapes, statistical figures, and an assessment of the groups or clientele they are working with:

(Supervisory Clinician) We do it [evaluation] in a lot of ways. I do it a lot by taping them and listening back over their sessions, and see how they are handling the patient. I also look at the dropout rates. For example, if they have twelve in a group and after three sessions, they are down to three, I am going to jump in there. With a good evaluation, you might look at the people and say, "Well, maybe this was a bad group to start with." Or you may look at the therapist and decide that his method of dealing with alcoholic people is not as good as his method of dealing with the children of alcoholics. It is difficult. I don't know that anyone has ever really gone into it. I see it as an interesting dissertation for somebody to do. How do you evaluate professionals?

Thus a broad and eclectic selection of information is combined with a supervisor's impressions to reach judgments concerning the performance of individual programs or therapists in the above cases. While formal evaluation such as goal attainment scores might be used as an additional source of information, it is difficult to see how any formal evaluation procedure can replace the flexibility and

openness of the above kind of reasoning.

Of course, the flexibility and discretion that enable some supervisors to make highly perceptive judgments in some cases can also lead to arbitrary and unfair evaluations in other cases. Indeed, some supervisory clinicians seem to have developed some rather questionable yardsticks for deciding which of their subordinates is doing a good job. The following clinician evaluates his subordinates on the basis of who comes to him for advise the least:

(Supervisory Clinician) I have heard other people saying the same thing: the person who is doing the best job comes to you least. That is, both they and their patients come to you with the fewest problems. I tend to think of them as doing the best job. That doesn't hold right down the line. Some of them may come to you for a lot of reassurance, to see if they are doing a good job. But that is different from them actually goofing up, the patients getting into trouble a lot. . . .

As the statement above suggests, much of the success of the therapy depends on the client rather than the therapist. Subjective evaluations can take into consideration the role that the client plays in the success of the therapy. Indeed, one supervisory clinician argues that there would be more value to an evaluation of the clients than an evaluation of the therapists. Likewise, he states that clients should be taught how to get more out of their therapy:

(Supervisory Clinician) Maybe the patient should see the data on his charts and maybe the patient should be evaluated. If you want to do research, do it on the patients and question them on how they can make the most of their opportunities. So, what I am saying is, that maybe we are doing research

from the wrong end--focusing in on the therapist. And, by God, we really ought to be looking at it from the consumer's point of view.¹⁰

Based on participant observation, it appears that most important decisions rely to a great extent upon subjective preferences and values held by the decision makers. Objective data and formal evaluations may be utilized in the making of such decisions, but they do not appear to determine the final judgment made. The objective data needed to make the specific decision may be unavailable. Even if such data are available, it is often ambiguous concerning the implications to be drawn.

A good example of the above points occurred in an organization in which there had been a long-standing debate about the value of an experimental program. This program used paraprofessionals, who are paid substantially less than professionals. Both the evaluator and director in this organization were skeptical of the abilities and performance of these paraprofessionals and desired to replace them with professionals such as psychiatrists. When several paraprofessionals left the organization, the director did not immediately fill their positions with other paraprofessionals but hoped to combine the salaries of several of these paraprofessionals.

¹⁰In fact, this clinician actually went to the evaluator and suggested that they begin a program like the one he describes in his comments here after the conclusion of this interview.

in order to hire a single professional.

However, many of the clinicians who were the supervisors of these paraprofessionals felt that they were doing an adequate or very good job. In fact, some preferred them to professionals because the paraprofessionals knew the communities better and spent more of their time in direct service. Many of the professionals served as consultants, moving from area to area. Such was the situation when the following exchange took place at a meeting when the evaluator and the director hoped to convince the others to hire more professionals:

(Evaluator) We need to take a look at the staffing pattern. This is a major question.

(Supervisory Clinician #1) We need to plan for a training program for the new paraprofessionals eventually.

(Evaluator) Would a paraprofessional be more practical than a professional?

(Supervisory Clinician #1) We need both but I would prefer one paraprofessional.

(Director) A professional could generate money.

(Supervisory Clinician #1) I don't see [name of a psychiatrist in the organization] generating money. He could but. . . . Sometimes we have more professional consultants in this area than people involved in direct service. And the patient care falls on my staff of paraprofessionals.

(Director) How effective do you find the paraprofessionals are in meeting the direct services? What is the optimum mix of the staff?

(Supervisory Clinician #2) You can't compare them to do the same things as professionals--if you are going to try to evaluate them.

(Supervisory Clinician #3) In my area, you have chronic problems and don't need any great psychotherapeutic skills. . . . Great intellectual problems don't exist.

(Supervisory Clinician #4) I would say that, in general, two paraprofessionals can do more than one professional.

(Director) But we don't have a good outcome study. For example, if one professional and two paraprofessionals take in five intakes, could that be done in a better way?

To carry out a good outcome study to determine the optimum staff ratio would take a great deal of time and resources and probably would still be open to questions of methodological weaknesses. More importantly, such questions as those above face the decision makers of these organizations daily. Decisions have to be made before rigorous studies can provide complete information. Directors, therefore, decide on the basis of preferences and whatever information happens to be available. Evaluative techniques such as goal attainment scaling, consumer satisfaction surveys, needs assessment surveys, and problem-oriented records are not designed to provide answers to specific organizational decisions such as how many paraprofessionals do work equal to that of professionals.

Decisions such as how to invest extra money also appear to be determined by a large variety of sources of information such as the waiting lists of different programs and feedback from the community as one director describes the process:

(Director) Well, when the time comes and that happens [additional money becomes available], you have a lot of things that help you decide. If you have good contacts with the community, they let you know what their needs are. For example, they call you and say: "I want this service and no one in the County has it and it seems to me to be in your province. Why don't you have it there?" Another thing is the waiting list. If youth services has such and such a waiting list, you start looking at what the community's needs are for youth services but also at how it is utilizing its people. Are they doing a lot of consultation or more direct service? So I would have to base it on several things. And I am sure that ten other factors would come into it that I can't even think of right now.

This decisional process is similar to that found by Nienaber and Wildavsky in recreation agencies (rather than the type which was supposed to prevail):

Evaluation is done ad hoc, in response to changing park conditions. It is surely not the type of analysis that will lead to radical changes in the agency's performance of goals. It does not question the fundamental assumptions of the organization, but it does respond to immediate problems with which Park personnel have to contend.¹¹

Unless evaluations are designed for specific decisions, they are likely to be very inadequate sources of information for making choices among alternative courses of action. Furthermore, simple data such as the figures on waiting lists or advice from significant members of the community will often be more influential than, for

¹¹ Jeanne Nienaber and Aaron Wildavsky, The Budgeting and Evaluation of Federal Recreation Programs or Money Doesn't Grow on Trees (New York: Basic Books, 1973), p. 53.

example, an epidemiological survey. Methodologically, simple evaluations are advocated by several directors and clinicians as indicated by the following comments:

(Director) How do you evaluate? There are so many obvious simple kinds of evaluations that never get thought of. For instance, a Center such as this one, which has been designated a bad Center, will change, for example, by hiring a sociological-anthropological type to interview everybody--the board, the staff and to develop a case history of what the community had developed in the way of service.

(Clinician) That is really exciting to me. It seems to me that what I am trying to say is that if we can get back to common sense, although I guess if you believe in common sense you also believe the world is flat, but there are a lot of simple things. You don't need a fancy evaluation. . . but simple kinds of questions with simple, honest answers. If you follow the statistics in psychology, the more polish the article has statistically, the less use it is. Simplicity in research is essential. If you get to the level where staff members, clients, et cetera, can all understand, then it is useful.

In summary, both participant observation and interviews indicated that formal evaluations are likely to play only a very small part in the making of most of the decisions in these organizations. Formal evaluation is only one of many kinds of data that form the basis of important decisions. Expectations of more than incremental change from formal evaluation are likely to be frustrated.

Some directors attempt to develop certain standards or ad hoc models against which to compare the performance of the personnel in the organizations. One director used industrial organizations as his frame of reference in determining the efficiency of the persons

under his supervision. He argued that in industry five-eighths is an efficiency criterion which the mental health organization should adopt as a goal for the fraction of total time that should be spent in direct service. The following situation occurred when the evaluator collected data which showed that an average of only about 15 percent of the clinicians' time was being devoted to direct service, far below the director's efficiency criterion of 62.5 percent. The director expressed dismay at the figures, but other clinicians in the organization were far less shocked:

(Supervisory Clinician #1) What is the standard against which we are measuring. . . ?

(Director) In some places twenty-five of forty hours is the standard. . . [cites a study]. . . and also industry and private practice. The only thing that counts is how much service, direct and indirect, that we are providing.

(Supervisory Clinician #1) I think that it should be how the people feel about us and the service we are providing, not the number of hours. . . .

(Director) Whenever you go into a place that hasn't had service before, they will think that you are great [the above supervisory clinician had responsibility for an area that had not had mental health services previously]. . . . Right now you are far below the 60 percent level and that is an administrative question.

(Supervisory Clinician #1) I don't think that really reflects the direct service. . . . People don't come in to see you twenty-five hours a week. . . [goes on to say that he spends much of his time on the phone with clients]. . . .

(Evaluator) But you don't get paid for that. You only get paid a fee for direct service.

(Supervisory Clinician #2) My whole concern is different--

a philosophical one. I am interested in providing indirect service and worried about putting too much emphasis on direct service.

(Director) I don't think that most of your paraprofessionals [who were under the supervision of the above clinician] are capable of providing indirect, consultee service. I really don't see that as a defensible figure--15 percent. If it were 40 percent, you could defend it, but it is embarrassingly low.

The above discussion illustrates the point that all data are potentially ambiguous. Also, skepticism concerning the technology of formal evaluation has been emphasized previously. However, it is evident from the above discussion that more subjective evaluations can arouse the same kind of skepticism and accusations of bias.

All evaluations, both formal and informal, are inextricably tied up in values. Thus evaluations are likely to arouse conflict unless there is an unusually strong consensus concerning values that should be emphasized. The ad hoc models used by different directors and clinicians to judge the efficiency and effectiveness of their organizations and programs thus revealed much about their value systems. Some directors emphasized a "private practice model" as the criterion against which the efforts of mental health organizations should be measured. Others disagreed with the analogy between private practice and public service:

(Director) If we can't do things as well as if we were in private practice, then maybe we should disband the organization. That is, if it costs more than twenty-five dollars an

hour, we should close down the place and have secretaries refer clients to private therapists.

(Child Psychologist) There is at least one fallacy--the clientele. It costs more to deliver services to poor people. The needs are different.

(Director) I am not suggesting that is what we should do, but that is something against which to measure our efforts.

(Child Psychologist) I can gauge how much I do by how much paper and client contact I have.

A very different kind of ad hoc model was developed at another organization where evaluations that focused on quantitative figures or analogies to industry were rejected in favor of an evaluation that was derived from the philosophy of humanistic self-actualization. The director of the organization argued that the only goal of the organization was to carry on non-exploitative relationships among themselves, with the clients of the organization, and with the total community. He stated that they completely rejected any technological model of evaluation. He indicated that the community would evaluate the work of the organization positively when they became aware that the organization was an "energy source" for the whole community.

However, while the philosophy of the organizational members rejected the idea of using numbers to evaluate its programs, nevertheless, the director kept several large graphs in his office that sought to demonstrate that the efficiency of the organization

had increased since they had adopted the philosophy of self-actualization. Also, the organization was continuing to collect and send to the agencies which funded them the numerous statistics required. The director admitted that he was compromising with the external culture and its evaluative standards even though he totally disagreed with them. In fact, it seemed clear that the members of this organization were determined to succeed in terms of the quantitative and technological model of evaluation in order to prove the worth of their philosophy to "outsiders." While this illustration strongly suggests the importance of the organizational struggle for survival, and also has implications for the issue of accountability (both of which will be explored in later chapters), here it demonstrates how all evaluations are inextricably intertwined in the value systems of the evaluators. However, because of their openness, formal evaluations are likely to make the values which they emphasize more clear than informal evaluations.

The fact that values influence evaluations creates the potential for continued conflict in organizations where there exist sharp differences in values held by different organizational members. In one organization, there tended to be a division into two groups that took opposing stands on several issues including the following:

Group One

- (1) favored emphasis on direct services
- (2) favored centralization in the organization
- (3) favored emphasis on poor, schizophrenic type of client
- (4) favored a higher percentage of professionals on the staff

Group Two

- (1) favored emphasis on indirect services
- (2) favored decentralization in the organization
- (3) favored emphasis on middle class, neurotic type of client
- (4) favored retention of the same percentage of para-professionals on the staff

Whenever an issue was discussed, each side would present the evidence in favor of its position. For example, the first group would emphasize the paraprofessionals' inability to handle individuals with complex problems, while the second group would cite the advantages of their knowledge of the community.

Sometimes objective data are entered into the debate, as when a psychiatrist with supervisory responsibilities examined the activity sheets of a sample of paraprofessionals and found that they had seen an average of only one-and-a-half clients a day. Such data are not unambiguous, however, because others replied that the efficiency of the paraprofessionals would increase in the future, or that they spent much of their time on the telephone with clients rather than seeing them directly. That the same data could lead to different decisions was pointed out by a supervisory clinician in another organization when he was asked if formal evaluation could

be used to determine the internal allocation of resources to different programs:

(Supervisory Clinician) The more I think about your question, the more merit I think it has--the individual program being evaluated in order to compare its efficiency with that of another program. There is a kind of intriguing element in it. I don't know what more to say about that but I think that there are certain phases of our operation here which are more efficient than others. If we did find this, we might not allocate more to the one that is more efficient but to the one that is less efficient, so they can get better.

The ultimate ambiguity of all objective data leaves the final decisions to be based on subjective judgments. When no consensus exists as to what these judgments should be, as in some of the cases cited above, the principle of hierarchy comes into play as the common organizational form of resolving such impasses. Thus the growth of formal, scientific evaluation is more likely to become part of the power struggle in organizations than to replace it.

Summary

This chapter explored the attitudes held by evaluators, clinicians, and directors toward formal evaluation. Attitudes toward informal evaluations were also examined. Data from questionnaires, participant observation, and interviews show that most clinicians strongly favor generalized evaluations which focus on the total organization or programs. Most clinicians were much

less enthusiastic or even opposed to the use of formal evaluations to judge the work of individual therapists.

Evaluators are no more favorable toward carrying out threatening evaluations than are the clinicians. Based on interviews and participant observation, this reluctance of the evaluators would seem to be due in large part to the unpleasantness they anticipated if they were to undertake such evaluations of co-workers. Thus, there was little evidence that the unprogrammed norms of the informal organization were directly responsible for the lack of impact of formal evaluations introduced in these organizations. There did not appear to be any active resistance to the evaluator. Rather, the effect of such informal elements was indirect: the evaluator anticipating resistance and attempting to forestall it by following a non-threatening way of introducing evaluations.

The clinicians rated skepticism concerning the technology of formal evaluation as the second greatest obstacle to its successful implementation. Even the evaluators recognized that evaluation technology was open to question. Yet, the kind of evaluation which all groups preferred, program evaluation, is presently much less developed technologically than evaluations of the individual therapist. This inconsistency suggests that attitudes toward technology are not based exclusively on an objective assessment but are influenced by other considerations, such as anxiety.

In the introductory chapter, it was noted that inductive hypotheses would be developed to enable future testing. The above arguments concerning the preferences of both clinicians and evaluators for non-threatening evaluations may be summarized by the following propositions:

(1) Persons being evaluated will favor those evaluations which minimize potential threats to themselves and maximize potential benefits.

(2) The degree to which evaluators favor non-threatening evaluations will be a positive function of the amount of resistance anticipated by the evaluator and a negative function of the amount of authority possessed by the evaluator.

The biggest obstacle to the acceptance of evaluation technology is a prevalent view that no two programs can be perfectly compared through formal evaluation. Some differentiative factor can always be found which tends to reduce such comparisons to preferences and values. Since most decisions involve such comparisons, this theme of "non-comparability" is seen as a potentially major limitation on the kind of impact that formal evaluation can have on the decisions made in these organizations.

Despite the existence of some skepticism concerning the technology of formal evaluation and anxiety about the way that such evaluations might be used, it did not appear that either the technological nor natural system elements of the organizations offered a good explanation as to why evaluation has had such little impact on the decisions made by these organizations.

Some examples of decision making were analyzed with particular focus given to the nature of the evaluations used to reach these decisions. Most decisions seem to be made through the combination of a variety of data available and the subjective preferences of the decision maker. Many clinicians and directors feel strong confidence in their subjective evaluations while evaluators, other clinicians, and directors strongly disagree with the validity of these judgments.

Yet, there seems to be no way of avoiding the necessity of relying upon such judgments. There is always a large degree of ambiguity after formal evaluation and objective data have been fully assembled. This ambiguity is partly due to the fact that formal evaluations simply are not tailored to provide the necessary information for the numerous kinds of decisions that arise daily. Even if complete information were available, ambiguity can still exist because different interpretations can be drawn from the same data because of differing values and perspectives of the specific individuals involved. It is concluded that the introduction of formal evaluation is likely to have, at best, an incremental effect on the operations of these organizations.

Values are an integral part of all evaluations, formal or informal. However, formal evaluation is more likely to make clear the kinds of values being emphasized by the evaluator than informal

and subjective evaluation is. When there is a disagreement as to values within these organizations, the introduction of formal evaluation can lead to conflict. There can be just as much skepticism and resistance to certain informal and subjective evaluations. However, decision makers are not hesitant to use subjective evaluations in reaching important decisions. By way of contrast, formal evaluations are rarely used in such decisions. Subjective evaluations are essentially the property of the individuals making them while more formal and scientific evaluations are public and open to challenge.

In this chapter, some of the reasons for the lack of impact of evaluation have been examined. Nevertheless, the existence of negative factors which prevent formal evaluation from having much impact does not explain what the positive forces were that led many of these organizations to voluntarily undertake some form of formal evaluation.

CHAPTER IV

THE FUNCTIONS OF EVALUATION

There are several reasons to be puzzled as to why the mental health organizations under study attempted to carry out formal evaluation:

(1) The evaluations consume or are expected to consume a significant amount of resources of the mental health organizations.

(2) There is little evidence of significant impact on policies or programs from the formal evaluation. Nor is there an expectation that such an impact is likely to occur.

(3) While there is some anxiety about evaluation and skepticism concerning its technology, observation of the way decisions are actually made suggests that any formal and scientific evaluation is likely to remain only a small part of the decision making process, even if anxiety and skepticism are overcome.

(4) The literature of organizational theory suggests that organizational survival and concern with goal attainment are opposed "concepts," particularly when the organizations are insecure, as is the case with mental health centers.¹

¹See Alvin W. Gouldner, "Organizational Analysis," in Sociology Today: Problems and Prospects, ed. Robert K. Merton, Leonard Broom, and Leonard Cottrell (New York: Basic Books, 1959), pp. 400-428.

In this chapter, the positive functions and motivations which led nearly all of the fourteen organizations to undertake some kind of formal evaluation and several to invest in a formal evaluation staff are analyzed.² First the preferences of the clinicians, evaluators, and directors are examined based on questionnaire data concerning what they regard to be the most important functions of evaluation.

These preferences are then compared with evidence from interviews and participant observation concerning the motivations which led the centers to invest in evaluation. The functions actually served by formal evaluation are analyzed.³ Finally, differences among the organizations in regard to their involvement in evaluation are examined in order to explain why some organizations are very interested in formal evaluation while others are not.

²All but one of the fourteen organizations visited had either undertaken or were planning to undertake some form of formal evaluation as defined earlier. Five of the organizations had invested in an evaluation staff at the time of the beginning of this study.

³In this chapter, "function" is being used to refer to the actual consequences of evaluation. Preferences expressed on questionnaires may be interpreted as attitudes concerning what should be the most important consequences of evaluation. See Robert Merton, Social Theory and Social Structure (2nd ed.; Glencoe: Free Press, 1957), p. 61 and W. G. Runciman, Social Science and Political Theory (Cambridge: Cambridge University Press, 1965), pp. 109-134.

The Preferences of the Staff⁴

It is clear from the literature on evaluation that formal evaluation can perform several functions.⁵ Based on a search of the literature, a list of nine functions was constructed and the clinicians, directors, and evaluators were asked to rank these functions as to their importance.⁶ Table 4.1 reveals that feedback and program evaluation are rated the most important functions of formal evaluation by the staff as a whole. Program evaluation is ranked as first in importance by the clinicians and directors. The evaluators ranked program evaluation second, after feedback, which they regard as the most important purpose of evaluation.

⁴The term "staff" is used to denote (unless noted otherwise) the composite of the three major groups responding to the questionnaires: clinicians, directors, and evaluators.

⁵See, e.g., Edward A. Suchman, "Action for What? A Critique of Evaluative Research," in Evaluating Action Programs: Readings in Social Action and Education, ed. Carol H. Weiss (Boston: Allyn and Bacon, 1972), pp. 52-84.

⁶Many of these functions overlap. The evaluation of the quality of programs would yield feedback to the clinical staff involved in the programs. Thus, the differences among many of the functions is one of emphasis. However, all were mentioned often enough in the literature (or in participant observation and interviews) to warrant being included in the list.

TABLE 4.1

THE FUNCTIONS OF EVALUATION

Please rank the following in what you regard to be their order of importance as functions of evaluation. Evaluation below refers specifically to formal evaluation carried out by an evaluator and his staff. (1 = the most important function, 9 = the least important function.)

- #1 Feedback for the clinical staff
- #2 Evaluation of the performance of individual staff members
- #3 Evaluation of the quality of the programs of the mental health organization
- #4 Provide accountability to the community
- #5 Provide accountability to the clientele
- #6 Increase the efficiency of the organization
- #7 Provide justification for the funding of the mental health organization
- #8 Determine the allocation of resources among the different service programs within the organization
- #9 Provide the means to regulate the organizational members' behavior

The following "index of importance" was constructed for each group by assigning nine points to the most important function (as rated by each respondent), eight points to the next most important, etc. Thus the following numbered functions with the greatest total of points were seen as being the most important functions by the respective groups.

Clinicians		Directors		Evaluators	
Number	Points	Number	Points	Number	Points
3	273	3	109	1	68
1	257	1	104	3	67
6	238	6	100	4	56
4	216	4	84	8	52
5	189	8	78	6	52
8	182	5	67	7	46
7	176	7	64	5	45
2	156	9	27	9	11
9	80	9	27	9	11

While the "soft" nature of the data warrants caution in their interpretation, particularly when only small differences are involved, there is a strikingly high level of agreement among all groups as to the most and least important functions of evaluation. Nearly all groups agree that the least important functions of evaluation are the regulation of individual staff behavior and the evaluation of individual staff performances.⁷ Clinicians and directors agree that efficiency and accountability to the community are the next most important functions, after program evaluation and feedback. In general, the responses in Table 4.1 support the view that the staff prefers evaluations which focus on programs rather than individuals. Indeed, the evaluators chose the least threatening function, feedback for the clinical staff, as the most important.

While the rankings provide a general overview as to priorities that the different groups assign to various functions of evaluation, more specific questions were also asked, particularly with respect to views concerning the "worth" of formal evaluation.⁸ An examination of Tables 4.2, 4.3, 4.4, and 4.5 shows that there is generally strong

⁷Several of the functions are closely associated with socially desirable or undesirable terms such as "accountability" and regulate. " Again, it was felt necessary to include them because of their importance despite the potential response bias. For example, some clinicians and directors argued (during participant observation and interviews) that evaluation inevitably involves the regulation and control of the staff.

⁸The questionnaire clearly defined evaluation as formal evaluation carried out by an evaluator and his staff.

support for the value of formal evaluation. Table 4.2 demonstrates that majorities of clinicians and directors reject the argument that formal evaluation is likely to cost more than it is worth. Most clinicians and directors also support the idea of devoting a larger percentage of the budget to evaluation as indicated by Table 4.3. Tables 4.4 and 4.5 show that most clinicians and directors reject the often stated arguments that evaluation is irrelevant and unlikely to be used in decision making.

A significant minority, approximately 30 percent for all three groups, agree that information from the evaluations is not likely to be used in decision making. The only other potentially negative note concerning evaluation is revealed in Table 4.6. Majorities of clinicians and directors agree that direct services should take precedence over evaluation.

In summary, the overall perspective as measured by the questionnaires is positive toward the worth of formal evaluation. There is especially strong support for certain types of evaluation such as program evaluation and evaluation for the purpose of feedback. These data reinforces the point that the staff much prefers program evaluation to evaluation which focuses on the individual therapist. Secondly, Table 4.1 demonstrates that accountability to the clientele of the organization is not ranked very high by any group (fifth by clinicians, sixth by directors, and seventh by evaluators). Accountability

TABLE 4.2
COST OF EVALUATION

It is likely that evaluation will cost more than the information derived from it is worth.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	---	---	---
Agree	7.9 (3)	6.3 (1)	---
Undecided	7.9 (3)	18.8 (3)	---
Disagree	76.3 (29)	37.5 (6)	66.7 (6)
Strongly Disagree	7.9 (3)	37.5 (6)	33.3 (3)

*Sum of percentage figures is greater than 100 percent because of rounding.

TABLE 4.3
PERCENT OF BUDGET TO EVALUATION

A higher percentage of the total budget (of the mental health organization) should be devoted to evaluation than is currently the case.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	7.9 (3)	37.5 (6)	33.3 (3)
Agree	76.3 (29)	37.5 (6)	66.7 (6)
Undecided	7.9 (3)	18.8 (3)	---
Disagree	7.9 (3)	6.3 (1)	---
Strongly Disagree	---	---	---

*Sum of percentage figures is greater than 100 percent because of rounding

TABLE 4. 4
RELEVANCE OF EVALUATION

Evaluation is unlikely to produce information relevant to the people performing direct services.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	2. 6 (1)	6. 3 (1)	---
Agree	5. 3 (2)	18. 8 (3)	---
Undecided	---	18. 8 (3)	---
Disagree	73. 7 (28)	25. 0 (4)	55. 5 (5)
Strongly Disagree	18. 4 (7)	31. 3 (5)	44. 4 (4)

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 4. 5
USE IN ADMINISTRATION

Most of the information derived from evaluation is unlikely to be used in actual administrative decision making.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators
Strongly Agree	2. 6 (1)	---	---
Agree	26. 3 (10)	31. 3 (5)	33. 3 (3)
Undecided	15. 8 (6)	25. 0 (4)	---
Disagree	47. 4 (18)	25. 0 (4)	66. 7 (6)
Strongly Disagree	7. 9 (3)	18. 8 (3)	---

*Sum of percentage figures is greater than 100 percent because of rounding.

TABLE 4. 6
EVALUATION AS LOWER PRIORITY

Evaluation is necessarily of lower priority than the direct delivery of services.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	2. 6 (1)	6. 3 (1)	---
Agree	50. 0 (19)	50. 0 (8)	44. 4 (4)
Undecided	10. 5 (4)	25. 0 (4)	22. 2 (2)
Disagree	34. 2 (13)	6. 3 (1)	22. 2 (2)
Strongly Disagree	2. 6 (1)	12. 5 (2)	11. 1 (1)

*Sum of percentage figures is unequal to 100 percent because of rounding.

to community is ranked as a more important function than accountability to clientele by all three groups. Nevertheless, the formal evaluations presently being introduced tend to emphasize evaluation by the clientele of the organization such as goal attainment scaling and consumer satisfaction surveys.

Another interesting finding is the fact that the one function that can be identified with the goal of organizational survival, namely "providing justification for the funding of the mental health center," is rated low in importance as indicated by Table 4. 1 The clinicians, directors, and evaluators rank this "survival function" as being

eighth, seventh, and sixth in importance respectively.

Consequently, the above data suggest that the functions regarded as most important by members of these organizations are related to program improvement rather than personal or organizational goals of survival. However, such conclusions cannot yet be drawn because of the need for additional information and the possibility of bias and misinterpretation in the responses to the questionnaire.⁹ Also, preferences expressed on questionnaires do not always predict or accurately reflect behaviors.¹⁰ Using data based on interviews and participant observation, the question of what role evaluation plays will be examined with respect to a problem that is often seen as being a serious obstacle to organizational evaluation: the organization's struggle for survival.

⁹The potentially strong value associations of several of the functions have already been noted. A second, more serious problem, is the possibility that respondents interpreted the question (though it was not stated as such) as "What should be the functions of evaluation?" In retrospect, two separate questions could have been asked: (1) What should be the function of evaluation? (2) What actually is the function of evaluation? However, since evaluation was restricted to formal evaluation carried out by an evaluation staff, the latter question would not have been meaningful to those organizations that did not have such a staff. Also, it is hoped that the distinction between the two above questions is made by comparing the questionnaire data with the interviews and participant observation data.

¹⁰See Allen P. Wicker, "Attitudes versus Action: The Relationship of Verbal and Overt Responses to Attitudes," Journal of Social Issues, Vol. 25 (Autumn, 1969), pp. 41-78.

Evaluation and the Struggle for Survival

The organization's "survival function" is a broad concept that can include a variety of activities. However, securing the necessary funding to provide for the salaries and resources needed by an organization is the prime factor that one thinks of as being necessary to insure organizational survival.

Organizations differ greatly in their security as far as funding is concerned, with some organizations being wealthy enough to be far removed from any overt sign of struggle for survival. There exists some variation in the group of organizations under study concerning their overall resources. However, there is strong evidence that most of the fourteen organizations in this study, and mental health organizations in general, perceive a crisis to be present in regard to obtaining the necessary funding and insuring organizational survival.

Mental health centers received highly favorable budgetary treatment during most of the 1960's, but they have fared less favorably in recent years.¹¹ Pre-planned decreasing federal contributions have forced these organizations to seek funds from sources other than the federal government. Most states are having

¹¹See Constance Holden, "Mental Health: NIMH Reeling Over Proposed Budget Cuts," Science, April 20, 1973, pp. 284-285.

their own funding difficulties and the clientele of most of the centers is relatively poor. As a consequence, there is anxiety concerning funding. This anxiety was reflected repeatedly in the interviews and participant observation. In the following illustration, the business manager of a mental health organization reveals that salaries for the forthcoming year were not even covered by funds which the organization could depend on:

(Business Manager) The salaries for next year will cost \$904,000.00 while income for the salaries is only \$78,000.00 plus a little more for secretarial personnel. One solution is not to fill positions as quickly as people leave.

(Director) We are not an expanding operation as we look to the future.

(Supervisory Clinician) Then we should not think in terms of growth and development but of contracting and atrophying.

During an interview with a clinician responsible for the programs in a certain area, a member of the county commission came in to deliver what the commissioner himself called a "bombshell." He said that the county commission had voted not to go along with what had been a pre-planned increase in the county's contribution to the funding of the mental health organization. Among the reasons why the commission had refused to go along, the commissioner cited resentment of programs "controlled by Washington" and a feeling that mental health funds were the most easily cut:

(County Commissioner) There was a conscious decision not to raise the millage rate, that the money had to be cut from the budget as a result, and that there should be a conscious decision to use revenue sharing dollars for. . . activities like landfill operations and building roads. They thought that the Mental Health Center was the prime thing that should be cut. I argued against the cut but some opposed it because they are opposed to anything out of Washington, you know, and others opposed it on the basis that it was the easiest thing to cut.

Further evidence of the "hard times" atmosphere present in these organizations occurred in a discussion at a Center where clinicians had been complaining about the vast amount of paperwork required by the State in order to obtain funds. "Outside pressures" were referred to in the argument used by the evaluator in reply to the complaints:

(Supervisory Clinician #1) You are not going to get less paperwork through a contractual set-up.¹² The whole process of evaluation depends on paperwork. But I share his [member of the evaluation staff] feeling about outside pressures and the need for records. I was in the position of justifying a \$250,000.00 program suddenly. Even though I don't like doing them, they are necessary and the question is how to make them easier and more relevant.

(Evaluator) The State wants answers to each of the questions on this intake form.

(Supervisory Clinician #2) I am not aware of what the outside pressures are. I am afraid to ask but I would like to know.

(Director) They concern the increased tendency to require payment for specific things, not just for an hour of

¹²They had been discussing the possibility of each program establishing a contract with the organization to achieve a more decentralized yet "accountable" form of administration.

therapy but for a consequence or outcome. You will have to have an evaluation of exactly what therapy achieves.

(Supervisory Clinician #3) They have been trying to do that for 100 years, like in the highway department. . . .

One final example of the concern with survival will suffice.

In this case, a director of a program describes how he had made out several budgets ranging from optimistic to pessimistic. His comments arouse a discussion concerning the future of funding for mental health organizations:

(Supervisory Clinician #1) I have five maps [budgets] and if they don't like one, I throw it out and. . . .

(Supervisory Clinician #2) But this is the big question: Is there a future in mental health, let's say two years from now?

(Evaluator) We are supposed to be so successful that we don't need support. . . .¹³

(Supervisory Clinician #3) But that is just an excuse. . . .

(Director) But the proposed national health insurance schemes may provide funds. . . .

To summarize, the organizational struggle for survival is no abstract phrase to the personnel of these organizations. Concern with survival is evident in their anxiety about the budgets of programs, about their salaries, and even about the future security of their jobs.

¹³This phrase was used several times by people in the field and apparently originated in the Nixon administration. But it was used in an ironic sense to imply that the Nixon administration was really trying to sabotage them through this kind of praise.

Moreover, the struggle for survival had the effect of creating tension and minor struggles among programs and even individual staff members for funds and salaries. Due to a lack of funds, struggles occur between different programs when heads of programs find that they cannot expand their service. Expansion for one program can only be achieved by a cut in the funding of another program as the following case illustrates:

(Program Head) What we [the staff of the program he headed] are asking for is a reallocation of staff.

(Director) You have to be conscious of the real world. Whose staff are you going to take away?

(Program Head) But we still have to look at the staffing patterns for different programs.

(Director) I think that most of the areas are going to say that they don't have enough staff right now.

(Program Head) Well, I will have to go back and redo my budget again.

(Director) One of the assumptions that I have made is that we don't fire lightly or move staff from one program to another, because of the problem of morale.

(Program Head) You mean to tell me that we are not going to look at the staffing pattern when it was arbitrarily set?

Stringency of resources brings out divisions among both personnel and programs in organizations. In such situations, programs attempt to prove their worth and excellence. In one case, a program director used the annual report of the organization to make detailed comparisons between the program he headed and similar

programs throughout the county. With data such as staff-to-patient ratios, his report cited figures which showed that his program was carrying a much greater burden than comparable programs in other mental health organizations. The same report also introduced several other kinds of information to show that this particular program had performed well, with the implication being that it should be rewarded by increased funding. In short, the program head had created an ad hoc evaluation of his own program in order to show why it should receive more funds and staff despite the scarcity of these resources.

The above cases illustrate the fact that the struggle for survival in these organizations often leads to increased tension in organizations. Concern with survival creates a situation in which programs are under pressure to justify the amount of money spent on them. Under these conditions of anxiety and tension, it would be impressive support for the concept of the "self-evaluating" organization if evaluations were carried out to fulfill idealistic functions to which the staff members had assigned the highest priority, such as program evaluation, feedback, accountability to community, and efficiency.

The Impetus for Formal Evaluation

Directors, clinicians, and evaluators were specifically questioned as to what the motivations behind the movement for evaluation are.

It is interesting to examine first the responses of the directors and personnel of those centers which had decided not to invest in a formal evaluation staff, even though many had considered doing so. The basic reasoning behind their decision was that an evaluation staff would cost money which they could not afford. One director openly states that an evaluator would not be "cost effective":

(Director) This cost is difficult to justify. We originally had a full-time research person written into our grant. We costed it out, and the amount of service did not justify the dollars cost. I didn't see how we could do it. We went the route of being primarily service-oriented, trusting that somehow we were doing some good.

Another director notes that the decrease in funds received from the federal government changed his mind about hiring an evaluator:

(Director) I think that we need somebody in the organization who has education, background, or experience in research and evaluation but now we have gotten to the point in our grant that we see clinical needs are more important--this was our last discussion concerning the matter [evaluation]--that we may not pursue this any further. We have so many clinical needs. Why should we flounder around, especially since nobody else seems to be doing anything much? So why should we go head over heels?

Not only do many staff members in these organizations feel that clinical service is the primary mission of the organization but also that clinical services provide the organization with money in the form of patient fees or through reimbursement from the State for certain categories of clients unable to pay their fees. A clinician in one organization which was not doing any formal evaluation describes the conditions which might lead the organization to establish an evaluation program:

(Supervisory Clinician) We have the capacity and capability of shifting from a service-oriented facility to a training or even research facility, of course, if ordered by whoever orders that sort of thing. Several of us could consider that if it were necessary for us to do it in order to eat. Then we could certainly do it.

Even in organizations with evaluation units, it is obvious that the costs of evaluation had been carefully considered, as the following director indicates in his response to a question: "Can you evaluate evaluation?":

(Director) Well, of course. For instance, one time our district board was interested in asking the State for a quarter of a million dollars for a research project when our total budget was only a million dollars. I questioned spending a quarter million dollars to evaluate a million dollars' worth of service. . . but one is concerned with the cost of evaluation and research. However, if it [evaluation] earns money, in other words, if it participates in putting money into the Center from the community or through research and evaluation grants, at least from a practical, capitalistic point of view, it is paying for itself.

Thus, pragmatic concerns with costs of evaluation led several organizations to decide against investing in an evaluation staff.

What are the positive inducements which led certain organizations to invest in formal evaluation and an evaluation staff? What might make directors think that evaluators are cost effective? Interviews and participant observation show that the basic impetus behind the movement toward evaluation is related to outside forces important to the organization's survival. Two points were continually emphasized in interviews and participant observation: (1) Organizational

members expect the problems of funding to continue; and (2) they perceive a growing movement toward accountability and the need to justify expenditures on mental health. Typical comments concerning the impetus in the movement toward formal evaluation include the following:

(Evaluator) Well, of course, I think that there is pressure from the government. You know they want to know that the money they are spending is doing some good. I think that in general any sort of human service agency is becoming more accountable to its clientele now, because people are saying, "Alright, damn it, our taxes are paying for this and that and everything you want from us. So let's see some evidence that what you do for these people is making a difference. "

(Director) Really, the main impetus [for evaluation] had been outside forces. The board of the Center, for one, wants to know what we are doing, and NIMH is asking us to be more accountable. Anyone who is receiving government funds knows that there is obviously a big push on for accountability and a little more than that, not just to account for hours, but whether or not you are really doing something. This is the impetus as I see it. . . .

(NIMH Official) We don't know what the future holds. . . . With revenue sharing, the county commissioners and the cities are going to get at some dollars. This calls for an additional emphasis to do something in evaluation efforts--to sell them to the community to get their support. . . . There will be those looking to see if they can get more bang for the buck.

(State Official) Evaluation and cost effectiveness are what the mental health boards are talking about. . . . These boards want to talk about evaluation in a different sense from what evaluators are usually thinking of, that is how do we justify the money being used to the community?

Even those centers which aren't doing very much as far as formal evaluation is concerned recognized these outside pressures. In one such organization, the author asked the following clinician

if all of the talk and interest in formal evaluation is just a fad:

(Clinician) No, it is economics. . . I think the government, politicians, and everybody are concerned about that money. They want to know if I am spending money, "How do I justify it? What am I getting for my dollar?" Which are perfectly valid questions. . . .

A director who is highly skeptical of evaluation predicted that the demise of formal evaluation would come if and when government funding ceases:

(Director) I can tell you exactly when it [evaluation] will evaporate--when government money runs out. That is the reason we do it, because we are forced to do it in order to get government funds. We are in a continuous process of what I call evaluation. They beg to differ in many instances but all of these forms--paper that they send out--are forms of evaluation, and they ask for statistics. You fill them out and that is just as much an evaluation for me as a balance sheet or income statement. . . . I can promise you that when this continuation grant application runs out we will no longer continue to write a continuation grant type of evaluation. It is too time consuming. It costs a fortune in man-hours and you don't even use it.

Thus, there is a great deal of agreement that outside forces and concern for organizational survival provide the underlying motivation for the movement to carry out formal evaluation of mental health organizations, programs, and personnel. Indeed, the frankness which characterized most responses to questions concerning this point merely reflects the fact that center personnel consider these facts to be common knowledge, at least in the mental health field.

The Benefits of Evaluation

Although there have been some indications of the benefits of

evaluation in the comments above, it still remains to be shown in detail exactly how formal evaluation contributes to organizational survival. At least four categories of actual or expected benefits from formal evaluation were identified: (1) evaluation as a defensive strategy in anticipation of future requirements for evaluation and accountability by funding agencies and district boards, (2) evaluation as a means of providing justification of the worth of mental health services to the community, (3) evaluation as a method of securing grants and other resources for the organization and individuals within it, and (4) the use of evaluation staff to carry out "non-evaluative" activities necessary or useful to the organization's survival.

Evaluation and anticipation

Evidence was cited in the introductory chapter that mental health organizations appear to be devoting a much greater amount of attention and resources than most other public organizations to formal evaluation. One of the reasons for this fact appears to be that members of organizations in this field are carefully scanning the environment to find methods of helping their organizations to survive. They see a chance to get a headstart on what they perceive to be an inevitable movement toward a requirement for formal evaluation of all service programs. Thus, when the author asked

one evaluator why the director of the Center had hired him, the evaluator replied:

(Evaluator) Well, as he [the director] expressed it to me, it was a case of doing something that was going to come anyway and that he would rather have our Center in the forefront of the movement.

Another evaluator expresses a similar thought, although in a more cynical tone, in response to the same question:

(Evaluator) That is a good question. At the risk of being unfair, he saw its major function as demonstrating to Tallahassee that we were a cued-in bunch down here, that we were on top of it, and out front with the best and most progressive kinds of techniques, which meant that we should get our fair share of the money.

Voluntarily undertaking evaluation is seen as a means of achieving greater input and control over the forms of evaluation likely to be imposed later:

(Director) The community is doing it [evaluation]. It is saying, "Do I want my United Fund dollar to go here?" or "Do I want my tax dollar going here?" So whether you think it is being done fairly or not, it is being done. And if somebody else is going to do it, you might as well do it yourself, coming up with some kinds of guidelines to feed back to them. If we don't do it, somebody else will do it for us. . . .

A final example of this use of evaluation occurs in the following exchange between a program head and a director. They are discussing the reasons for attempting to put together an extensive program budget. In this budget, different programs would promise to provide a certain number of service units per dollar:

(Program Head) Is this a fee-for-service thing? Are we going to use this as a justification for getting money and not just for the board?

(Director We are trying to get a jump on what will be required of us in the future. . . . You can say you are going to get paid for each patient cured. . . .

(Program Head) If that is the case, we are in trouble in this business. . . .

The question arises concerning the reason why mental health organizations are unusually concerned with getting a headstart on formal evaluation. They are not the only group of organizations which have experienced funding difficulties. Their concern with getting a headstart on future requirements seems to be the result of the interaction between two factors: (1) the fact that they perceive themselves to be in funding difficulties, (2) the fact that they are composed substantially of highly educated professionals who carefully scan the environment in order to anticipate trends that might affect or benefit their organizations.¹⁴ Organizations with fewer problems in funding do not have to be so concerned with the future. Ones composed of leadership with less experience and capability of scanning the environment and anticipating the future are not likely to give evidence of so much concern for evaluation until it is actually required of them.

¹⁴Another example of an organization with a similar combination of conditions is NASA which has made a strong attempt to prove the worth of its technology to areas other than the space program, particularly after it began to fare less favorably in appropriations. See, e.g., Raymond A. Bauer, Second Order Consequences: A Methodological Essay on the Impact of Technology (Cambridge: M.I.T. Press, 1969).

It is also interesting to draw an analogy between the actions taken by mental health organizations as a whole and the behavior of the evaluators within them. As noted earlier, most of the evaluators had anticipated difficulty in their role (perhaps because of reading or hearing about the problems of doing research and evaluation in service-oriented organizations). They undertook non-threatening evaluations in order to prevent any difficulty. It seems that the rule of anticipated reactions is particularly important in situations when educated and intelligent individuals or groups of individuals face difficult and uncertain situations.

Evaluation and the worth of mental health services

While several directors and clinicians are pleased to undertake evaluation in order to get a headstart on other organizations, they also expect the evaluators and formal evaluation to contribute something of more immediate value to the organization. In particular, they see evaluation as a means of justifying the money already spent on mental health and, if possible, providing justification for asking for even more funds.

In discussing the popularity of psychiatric epidemiological surveys, it was noted that these surveys are often expected to show a great degree of prevalence of mental illness. Thus, they are likely to furnish "hard data" to support requests for more

mental health service. A good illustration of this point occurred at a meeting attended by the author. A researcher presented a detailed critique of psychiatric epidemiological surveys. He argued that they are virtually worthless for making decisions concerning the provision of mental health services. In reply, one listener, who is a member of a mental health district board, replied briefly: "You have to have incidence to get dollars."

An evaluator describes how she thought that the director of the organization conceptualizes her role:

(Evaluator) I think that [name of the director] wanted information to back up his arguments on money that he had to make to people concerning the Baker Act.¹⁵ For example, does the Baker Act really mean that we are taking the burden off the local police department, the local hospitals, and providing more local care? And he did not have the mechanism to get this information before I was here. . . .

A director describes how he is using his evaluation staff to see if the Center is getting its fair share of funds from the State:

(Director) I don't know if we can do this, but we have gotten some statistics together which we think that we can use for the State when we question their funding. . . since the adjoining county received \$800,000.00 for the Baker Act and we only got \$150,000.00 to \$200,000.00 in our county when we had an extremely high rate of admissions. . . .

A supervisory clinician responsible for administering mental health services in a certain area got together statistics demonstrating

¹⁵The "Baker Act" is the title given to legislation related to the funding of mental health centers in the State of Florida.

the worth of mental health services to the county. The evaluator in the organization indicated the he was interested in seeing how the clinician had arrived at these figures." The figures cited by the clinician included the following points:

It is estimated that \$10,000 worth of services has been provided to the sheriff's department and county. Specific services can be verified including the following: (1) a minimum of forty days jail time saved on mental patients. . . (2) evaluation and counselling ordered through the Division of Youth Services is calculated at \$300.00. . . . \$10,000 worth of service has been provided to the county schools. In-service training and consultation have been provided in seven of the county schools. . . .

Many of these ad hoc evaluations are collections of statistics put together to show the services of the organizations in as favorable a light as possible. No cases could be found of mental health organizations deliberately presenting information that reflected unfavorably on their work. Yet, some potentially negative statistics were available for some of the organizations. For example, the mental hospital load and inpatient figures had failed to decrease in many areas despite the new mental health act which established support for community mental health centers.¹⁶

¹⁶Of course, as noted in Chapter III, all evaluations and statistics have some ambiguity associated with them. The failure of these figures to decrease was seen by many in the field as merely the consequence of the fact that the mental health organizations were simply discovering cases which had previously gone undetected.

The pressure to generate data that show that the costs of mental health service are justified is present even in those organizations that have no formal evaluation staff, as the following case illustrates. The director of this Center speaks enviously of rehabilitation programs and their public relations:

(Director) The model of successful public relations is rehab [rehabilitation programs]. They worked out a ratio of the amount of taxes paid as a result of rehab and then the amount of the costs of the programs, and, . . . the amount of taxes paid by the people [the people rehabilitated by the program] was twelve times the amount of the cost. So rehabilitation has an excellent relationship with Congress while mental health has never generated such positive findings. We have only generated a sad story. . . . That is one of the reasons why I am interested in getting data on employment of people served by our agency. We have no idea of how many people have gotten jobs.

While most staff members, including clinicians and evaluators, accept the need to generate such data, there is clearly no great enthusiasm for collecting them. The data lack rigor and relevance, being regarded as highly questionable at best. One clinician who had participated in collecting such data describes his attitudes toward it:

(Supervisory Clinician) Of course, that is invalid. I was involved in a situation where we tried to show for x amount of dollars spent how much we had saved. How are you going to do that? We got on the radio and then after we left the studio of the place, we tore up the notes so that the poor other guy coming along later wouldn't have to defend the figures.

Clearly, these kinds of activities are not open evaluations aimed at measuring the degree of goal attainment. They are calculated to demonstrate positive results. The willingness to

collect this kind of data rests on assumptions such as the following:

(1) that the costs of the organization are justified, even if it is difficult, if not impossible, to demonstrate this worth in dollars and cents figures, and (2) that it is necessary to present the organization in as good a light as possible.

Evaluation and grants

In addition to giving organizations a headstart and helping to justify the dollars spent on mental health, evaluation contributes to the survival of the organization by bringing in grants. Many of the evaluation programs are either receiving or expect to receive direct support from the state and federal governments. One of the evaluators admitted the importance of this money when asked if the amount of money a Center invested in evaluation could be used as a good index of the organization's interest in self-evaluation:¹⁷

(Evaluator) Not necessarily. If somebody could give us a grant, and the Center may not have any particular interest or investment in evaluation, but if somebody gave us the grant to do it, then I think. . . it would create interest in the field. . . .

A state official attempting to implement an evaluation program indicated that the promise of a share in the money from a grant had

¹⁷This example illustrates the difficulty of finding rigorous data to test Wildavsky's question. Certainly the amount of money spent on evaluation is not a good index of desire to carry out critical self-examination when the money is derived from external sources.

persuaded a director of a Center initially opposed to evaluation to go along with the program. A director of another organization, after hearing several speeches on evaluation by directors of organizations undertaking formal evaluation, questioned their motives. He said that he knew their "hearts were pure" but there was the probability that desire for funds had stimulated much of their interest in carrying out formal evaluation.

In addition to grants which are specifically tied to evaluation activities, many of the grants received from NIMH or other sources now require that proposals have an evaluation section included within them. For example, if an organization wishes to get a grant for services related to treatment of alcoholism, it probably has to include within the grant a method for evaluating the effects of the program. To summarize, much of the self-evaluation being undertaken by the mental health organizations under study is either directly supported by outside funds or is being undertaken with the expectation of receiving such support in the future. Thus, it is impossible to determine how much interest they would have expressed in formal evaluation if they did not expect to receive outside support.¹⁸

¹⁸Some people in the evaluation field argue that inexpensive evaluations that are fairly rigorous and comprehensive can be carried out. See Allan Beigel, Evaluation on a Shoestring: A Suggested Methodology for the Evaluation of Community Mental Health Services Without Budgetary and Staffing Support, Program Evaluation Series, No. 5 (San Francisco: University of California, November, 1973).

Changes and innovations in organizations often result from "extra" or slack resources, whether these are obtained from the outside or are derived from the strong financial status of particular organizations.¹⁹

Evaluators and non-evaluative duties

The fourth major category of benefits from undertaking formal evaluation accrues only to those organizations that have formal evaluation staffs. These staffs perform a large number of non-evaluative tasks in the organization such as data gathering, general administration, planning, and other duties.²⁰ The following evaluator describes some of the common activities that he or his staff undertake in addition to their evaluative tasks:

(Evaluator) I do a lot of service kinds of things for people here, because it seems to work really very well if you do. For example, the administrative assistant will come in and say, "Gee, we have a board meeting and wouldn't it be great if you could get such and such information?" Whoever [on the evaluation staff] has the time, will work on that too, because that would be something that they need tomorrow or today or an hour from now. And these kinds of things pop up all of the time.

¹⁹See Victor A. Thompson, Bureaucracy and Innovation (University: University of Alabama Press, 1968), pp. 40-45.

²⁰Some of these tasks include gathering data that are used in evaluative ways by outside agencies but they do not conform to our definition of formal evaluation and are not used for internal evaluation purposes.

The evaluator went on to point out that most of the material the evaluation staff collected is "really simple-minded" and descriptive in nature (e. g. , the number of persons who attended the clinic during a certain period).

A member of the evaluation team at another Center describes the kinds of activities which she had been doing for most of her career in this organization:

(Evaluator) I used to keep track of all of the admissions, discharges, types of therapy and all of that which is now on the computer. And I just found myself fed up to here. I was at wits end because they were trying to do this or that kind of report and were calling me up. . . . I would have to go through the papers for every day of the year. . . . I just didn't see that as very important.

Many of the clinicians in organizations with formal evaluation staffs also see the evaluators as being generally involved in non-evaluative tasks:

(Supervisory Clinician #1) I have seen the [department responsible for evaluation] as being involved almost entirely in administration functions, and it has not been really able to begin any research. . . .

(Supervisory Clinician #2) I would like to see them [the evaluation staff] give us programmatic suggestions. In the first year, they seemed to be caught up in gathering data and reporting to the board, such as with the alcoholism thing. . . .

A clinician in another organization sees the role of the evaluators as providing descriptive data which the clinicians and program heads interpret:

(Supervisory Clinician) They [the evaluators] did a pretty good job with keeping up with the programs and telling us how many patients had come in. For instance, in one company, we weren't receiving as many patients as we thought we should and we went back and asked them why. . . . If the researcher hadn't come back and said that we were only getting forms from the wives or self-referrals rather than referrals from the management of the company, the therapists might not keep up with this information. . . . We went back to the industry and found a block there--a personnel manager who just wasn't enforcing the referral system.

Thus, much of the work done by evaluators is either involved with the details of administration or providing descriptive data to clinicians.

There is a scarcity of people with the time and skills to carry out the many data gathering and administrative duties in these organizations. The role of the research and evaluation staffs is often seen as being to help fill this void:

(Evaluator #1) Well, [name of the director] has his own agenda, and in his agenda anything that I can do to take weight off of his shoulders in terms of administrative duties, especially in his relationships with the State and board and the like, is of primary value to him.

(Evaluator #2) I was the logical person to get him [the director of the Center] that information. There were other people but they had so many other things to do, or they didn't really know how to get this kind of information. And so it just kind of fell to us to get it.

The newness and flexibility of the role of the evaluators apparently reinforces the tendency of administrators and clinicians in these organizations to rely upon them to carry out administrative and data gathering tasks.

How important are non-evaluative activities performed by the evaluators in comparisons with evaluative ones? There is variation among the organizations studied concerning the amount of time devoted by the evaluation staffs to non-evaluative activities. In at least two of the five organizations which had evaluation staffs, it appeared that these non-evaluative duties are consuming a large percentage of their time.²¹ Pressman and Wildavsky argue that the actual allotment of time to various activities is the best way of finding out their relative importance:

If you want to know what matters most to an organization, chart the activities on which its members spend their precious allotment of hours. The allocation of time deserves, though it does not receive, the same attention that we give to the allocation of financial resources.²²

In Table 4.7, the activities performed by the evaluation staff at one Center are outlined.²³ This description of their activities is based upon reports made by the evaluation staff describing their own

²¹This statement is based on estimates of the evaluators themselves, interviews with clinicians and directors of the two organizations, and, in one case, extended participant observation.

²²Jeffrey L. Pressman and Aaron Wildavsky, Implementation (Berkeley: University of California Press, 1973), p. 121.

²³The evaluators in this organization did have formal responsibility for planning and program development in the organization. To a certain extent, then, the focus on non-evaluative activities is based on actual formal duties. But the extent and consistency to which these latter activities displaced the evaluative ones is the issue here.

duties. It substantially agrees with estimates of activities performed based on the author's participant observation and interviews with the evaluation staff and clinical personnel of the Center.

TABLE 4.7

ACTIVITIES PERFORMED BY AN EVALUATION STAFF
AT ONE CENTER

(1) Accounting Activities, Billing Systems, Accountability Forms, and Administration of State Laws: The evaluation staff is substantially involved in all of the above activities. Each of these activities normally consumes a substantial portion of the evaluation staff's time each day. Each of the activities is necessary for the Center to obtain needed funds from clients and other sources.

(2) Continuation Application, District Plans, Foundation Support, and Other Plans and Grant Applications: The evaluation staff spends considerable amounts of time on each of the above activities. The continuation grant application and the district plan both take several months to complete. The other grants and plans carried out by the evaluation staff also take substantial amounts of time such as several weeks to complete.

(3) Operational and Comprehensive Planning: Members of the evaluation staff are responsible for carrying out operational planning in response to problems that arise daily. Also, one of the members of the evaluation staff is assigned to carry out more comprehensive, future-oriented planning.

(4) Prevalence Study, Consumer Satisfaction Study, and Goal Attainment Scaling Evaluation: The evaluation staff has begun to carry out a prevalence study of mental health needs in the Center's catchment area, although this study was delayed. At the time of this research project, they were planning to carry out consumer satisfaction surveys and goal attainment evaluation with respect to certain programs in the Center.

Many of the activities performed by the evaluation staff are purely administrative type of activities such as those in category one of Table 4. 7. Activities such as setting up billing systems, collecting data requested by funding agencies for accountability purposes, and implementing state laws are duties which are necessary if the organization is to continue to receive funds from the State and its clientele. These activities take up a large part of the evaluation staff's time each day.

Likewise, the activities listed in category two of Table 4. 7 are important to the survival of the organization. They have to complete the continuation grant application and the District Plan if they are to receive funding from the national and state agencies respectively. This type of activity cannot be postponed because these grants and plans have deadlines associated with them.

Operational planning referred to in category three also involves activities characteristic of day-to-day administration. The evaluation staff in this Center did allocate specific individuals to have responsibility for comprehensive planning and evaluation. However, when deadlines approach or someone is needed to help with these administrative duties, these persons often dropped their planning and evaluation activities to help perform these other duties.

Thus, the evaluators, clinicians, and director of the Center noted that the evaluators have little time to focus on formal evaluation.

They are continually displaced from attempts to carry out formal evaluation and directed toward the many administrative duties required to support the existence of the organization. In contrast to the administrative activities, the evaluation activities carried out at this Center had no such deadlines associated with them. They did not promise any kind of direct financial return to the Center except in cases where evaluation efforts are directly supported by funding. The result of this situation is that activities that are not directly associated with funding and that have no deadlines or penalties attached are constantly sacrificed to more pressing demands.

This same kind of displacement from evaluation toward administration occurred in at least one other Center. There are several potential explanations for this phenomenon in these two Centers. A version of "Gresham's Law of Planning" states that programmed activities tend to drive out non-programmed activities.²⁴ In part, this behavior may reflect the tendency of persons to become attached to routines or to respond only to deadlines and crises.²⁵ It may also reflect the deliberate cooptation of the evaluators by the

²⁴See Herbert A. Simon, The New Science of Management Decision (New York: Harper and Row, 1960), pp. 1-13.

²⁵Over-attachment to routines is one form of what is called "bureaupathology." See Victor A. Thompson, Modern Organization (New York: Alfred A. Knopf, 1961).

director and clinical staff of the organization as the following evaluator suggests:

(Evaluator) It goes to this whole business of the cooptation of the evaluator. And I think in many senses that that might be what is going on around here: that there is a substantial fear that we have the skills, that if I am left enough time to do the job with my staff, that we could probably come up with some fairly sophisticated methods for evaluation. I am not saying it is overt but it may be an unconscious feeling on their part. . . .

On the other hand, another evaluator in the same Center doubts the sincerity of the other evaluator's protests against the many non-evaluative duties he performs:

(Evaluator) He [head of the evaluation staff] tells me that his main interest is research, that he doesn't like administration and all of that, but I know he likes it or he wouldn't be doing it. That's him. . . .

One evaluator in the same organization also noted that some of the members of the evaluation staff see their major chance of mobility as being within the area of administration. In short, personal ambitions and attachment to bureaucratic routines may explain to some degree why evaluators in two Centers spent so little time evaluating.

A different interpretation which is supported by evidence from participant observation and interviews, is that these programmed activities are visibly associated with the organization's survival and thus receive a higher priority than other activities, like measuring the degree of goal attainment through evaluation. While evaluation has

certain benefits expected to be derived from it, such as getting a headstart on future requirements, administrators in two of these Centers found it highly tempting to use evaluators for activities which are more directly supportive of the organization's survival.

In short, three conditions seem to make the displacement of the evaluators away from evaluation activities highly likely in these two Centers: (1) the fact that the organization is perceived to be in funding difficulty and concerned with its survival, (2) the commitment of the leadership and staff of the organization to the organization's survival, and (3) the perception that evaluation is not as directly supportive of the organization's survival as other non-evaluative activities. In the organizations in which there has been less displacement of the evaluators from evaluation, evaluation appears to be more highly regarded because it has brought in funds through grants directly tied to evaluation.

One final fact from the listing of the activities performed by the evaluation staff in one Center should be noted in Table 4.7: the tremendous amount of time devoted to paperwork required by outside agencies and the district board.²⁶ The large amount of paperwork

²⁶The activities performed by the evaluation staff described in Table 4.7 represent only one case. However, most of the same activities are carried out in all of the other thirteen organizations. However, in some cases, the evaluation staffs appeared to be less involved in the administrative duties.

required to be filled out as part of their jobs irritated many of the clinicians in several organizations studied. When clinicians were asked what part of their jobs they like least, many replied that it is the paperwork or "filling out forms for the State." One clinician stated that he felt that he and his colleagues are becoming a "race of administrators." A director expresses his frustration for the continually escalating demands for outside evaluation:

(Director) We have community evaluations. We have a committee of the medical society, for example, coming here to meet with our program directors, evaluating our programs, later this afternoon. Last week we had a two-day evaluation from the State Division of Mental Health. They spent two days with us and we will have a site visit for our child development grant. We have all sorts of requests for these things. . . . Every time we submit a grant to the state or federal government--they have a committee that comes in. We are evaluated to the point that we say, "Great God, here comes somebody else to evaluate us."

The paperwork required by the outside agencies also tends to make many of the clinical staff vent their frustration on the inside evaluators who often actually have to collect the data:

(Supervisory Clinician #1) I am not against accountability and research but in the last year paperwork is increasing. . . the whole thing about paperwork--how it has been laid upon us as a method of control.

(Supervisory Clinician #2) The categories on it don't accurately reflect what I am doing.

(Supervisory Clinician #3) Those cards look more relevant.²⁸

²⁸The computer cards replaced the activity sheets.

(Director) Yes, the activity sheets are a method of control but is that bad or wrong?

(Supervisory Clinician #1) The amount of resources devoted to research and evaluation is too great. We need evaluation and research but how much do we need them in comparison with direct services?

As noted above, most of the data required by the funding agencies and district board are used by these outside organizations to evaluate the performance of the local centers. The amount of effort required to meet these requests for outside evaluation and accountability appear in some of the organizations studied to create resistance to internal evaluation. In short, the acceptance of internal evaluation by the personnel of an organization may be inversely related to the amount of evaluation required by outsiders.²⁹

Summary of the costs and benefits of evaluation

In the large majority of the organizations studied there is concern with the survival of the organization because of current funding difficulties. Evaluation usually takes up a significant amount of resources. It may also generate anxiety. Personal values and ambitions are important in the decision to invest in formal evaluation and hire an evaluation staff. But from the viewpoint of the survival

²⁹On a few occasions, such data may be used internally. In at least one case, they were used by the evaluator and director to support their arguments concerning the way that the clinical staff spent their time.

of the organization, the following categories appear to be the major costs and benefits (either actual or expected) associated with formal evaluation in the fourteen organizations under study:³⁰

<u>Costs of Evaluation</u>	<u>Benefits of Evaluation</u>
(1) Money, time, and resources used by the evaluation staff	(1) Use of evaluation to anticipate future requirements to achieve greater input and control over future evaluation
(2) Time and other resources used by the clinical staff members in cooperating with the evaluation	(2) Use of evaluation to justify funds spent on mental health services and to support requests for more funds
(3) The anxiety, tensions, and conflict generated by the evaluation	(3) Actual or expected increases in funding, grants, and other resources as a result of undertaking formal evaluation
(4) The potential costs of a negative evaluation or irrelevant evaluation upon the prestige and morale of the organization	(4) Contributions of the evaluation staff to non-evaluative activities such as administration, data gathering.

Thus, interviews and participant observation support the view that pragmatic concerns with survival tend to play a more important role in stimulating interest in formal evaluation than the idealistic functions chosen as most important on the questionnaires.

³⁰ It is difficult to separate an individual's values and personal ambitions from those which he holds as a result of the roles that he plays in the organization. See A. Paul Hare, Handbook of Small Group Research (New York: Free Press, 1962), p. 8.

The differences between the responses to the questionnaire and the functions actually served by evaluation may be due in part to the limitations of the instrument. However, they are also likely to be in large part the result of the tendency of our ideal motivations to be displaced by more pragmatic concerns--a variation of the previously mentioned Gresham's Law of Planning. An example of this tendency occurred in an interview with a psychiatric social worker who responded in the following manner when asked to identify the major function of evaluation:

(Supervisory Clinician) Helping to determine which activities are helpful and produce results and which ones haven't and can thus be abandoned.

But when the same clinician was asked what functions the evaluators in the Center had actually performed with respect to the program she was involved in, she replied that it was in helping to write up grant applications so that she didn't have to worry about them or have "those wild fancies myself." She, herself, noticed discrepancy between this description of the duties performed by the evaluation staff and what she had indicated earlier to be the most important function of formal evaluation. Commenting on this discrepancy, she states the following:

(Supervisory Clinician) If they get more staff, I would like to see them help more in determining what I referred to earlier, that which is effective and that which isn't. . . .

In short, there seems to be a disparity between idealistic preferences of the staff concerning the functions of evaluation and the way that it is actually used.

Organizational Differences

Interviews and participant observation suggest that there are differences among organizations concerning their perspective toward formal evaluation. Some of these differences have already been noted. In Chapter III, we saw that evaluation is closely related to the values of the personnel of the organizations. In some organizations, there appears to be a fairly cohesive set of values, and consequently, a fair degree of agreement on how to evaluate the services offered by the organization. In other organizations, there are sharp differences in the values held by different groups of organizational personnel making it virtually impossible to achieve a consensus on how to evaluate the work performed by organizational members.

In this chapter, we have already noted that certain organizations appear to be much more willing than others to invest in formal evaluation. The question naturally arises as to what are the important factors which lead some organizations to be more interested than others in formal evaluation. The data used to determine these factors is basically "soft" including interviews and participant observation. Also, inferences beyond the particular group of organizations studied are problematical.

Given these limitations, it appears that the attitude of the director of the organization toward formal evaluation is a key factor

in determining whether these organizations invest in evaluation and an evaluation staff. One evaluator describes the role of the director as follows:

(Evaluator) He [the director] was the impetus. His first idea when he came to the clinic was to conduct a survey of the needs of the community. Then he started talking with a variety of people in the State and got into program evaluation as a result of that. . . . He brought that back to the staff who said yes also.

A director who decided to undertake a consumer satisfaction study but not yet to invest in an evaluation staff openly admits the crucial importance of his own role:

(Director) I think that it is important what the director thinks--where you put your emphasis. I don't think that unless I put emphasis on it [evaluation] that it would be adhered to. I initiated the consumer satisfaction study and the initial reaction was negative. I don't know how it is going to work out, since I am obviously ambivalent about evaluation myself.

Another example of the director's importance occurred in a Center where the director became interested in evaluation and subsequently began to carry out some of his own evaluation besides having his Center associated with other organizations involved in evaluation. These activities ceased when he subsequently left the Center and a new director who had no interest in formal evaluation took over.

Of course, other factors can influence the director's degree of importance, such as his style of administration, the extent of his authority, and the "climate" of interpersonal relationships in the

organization.³¹ Yet, even in a Center which covered an enormous catchment area and was supposedly moving toward decentralization, the director indicated in an interview with the author that he thought that he could "pretty well take care of the evaluation programs," including internal resistance to it, if he had the support of the district board. In short, all of the directors, clinicians, and evaluators with whom the author spoke agreed that strong support of the director of the organization was crucial in order for an evaluation program to be established.

Evidence concerning other potentially important factors is more ambivalent. The financial condition of the organization might affect attitudes toward investing in formal evaluation. It would seem natural for a "poor" organization to be less inclined to engage in evaluation than a "rich" organization with slack. However, the possibility of getting grants might encourage a poor organization to go into evaluation. A rich organization would not have this incentive to the same degree. Therefore, the effect of the financial factor is problematical.

In other words, the potential benefits of evaluation might seem more impressive to a struggling organization but so would the costs,

³¹ See Fred E. Fiedler, A Theory of Leadership Effectiveness (New York: McGraw-Hill Book Company, 1967).

while the opposite would be true of a more wealthy organization. Unfortunately, it was impossible to collect "hard" data concerning the amount of slack actually available in an organization. Indeed, it has been argued that slack is actually a "psychological" variable.³² Regardless of how defined, subjective evidence accumulated during the interviews indicated that both the objective and subjective amount of slack of the organizations which invested heavily in evaluation roughly paralleled that of those organizations less committed to evaluation. Of course, nearly all of the organizations appeared quite concerned with finances.³³ Another potentially important variable is the size of the organizations. On the one hand, it might be easier to introduce evaluation in a smaller organization. On the other hand, larger organizations are likely to have more resources to invest in such activities.³⁴ The organizations most

³² Thus a fiscally conservative organization might require much more substantial reserves or "surplus" than a more liberal-minded (fiscally) organization before undertaking an extra activity, such as formal evaluation. This would make it impossible to determine the amount of slack based only on their financial status. See Victor A. Thompson, Bureaucracy and Innovation, pp. 43-45.

³³ The one organization which appeared to have slack did invest in a research and evaluation staff.

³⁴ James Q. Wilson argues that the size of an organization has an ambiguous effect on the amount of innovation that takes place in organizations. See James Q. Wilson, "Innovations in Organizations: Notes Towards a Theory," in Approaches to Organizational Design, ed. James D. Thompson (Pittsburgh: University of Pittsburgh Press, 1966), pp. 193-218.

heavily involved in evaluation ranged from the very small to some of substantial size.

There is one other factor that interviews and participant observation indicated to be of some importance in determining the extent of interest organizations have in evaluation--the nature of the ambitions and values held by important individuals in the organizations. It has already been noted that the values and attitudes of the director can be important in determining the nature of the evaluation and degree of emphasis put on it. However, up until this point, the director's attitudes have been discussed mainly in terms of his organizational role (e. g. , his goals for the organization and his interpretation of the costs and benefits that evaluation would contribute to its survival).

One does not have to be cynical to know that personal ambitions, and not just formal obligation, play an important part in the behavior of individuals. There appeared to be some correlation between interest in investing in formal evaluation and achieving recognition beyond the local organization.³⁵ For example, staff members from two of the organizations most advanced in evaluation had achieved

³⁵This is similar to the distinction made between localism and cosmopolitanism orientations discussed in organizational and sociological literature. See Alvin W. Gouldner, "Cosmopolitans and Locals: Toward an Analysis of Latent Social Roles--I," Administrative Science Quarterly, Vol. 2 (September, 1957), pp. 281-306.

some degree of recognition in the field through delivering papers at conferences, having references made to their evaluations in publications in the evaluation field, and receiving numerous visitors to observe and "adopt" their "model" of evaluation. A member of the staff at another Center admitted that he thought the head of the evaluation staff was thinking about publishing some survey research they were doing. Another evaluator stated that evaluation is more important than his other duties because of the potential recognition to be achieved from it:

(Evaluator) Going back to the original point of view, that my career is ultimately going to be aggrandized by the publications that I have got, and that my future is dependent upon my production in that sense, the evaluation component is most important.

In short, personal ambitions, both of the directors and other key members of the staff of the organizations, can affect the interest or lack of interest in evaluation, depending on if these individuals see evaluation as contributing to the accomplishment of their personal goals.

Interest in evaluation also seems to be positively related to a general interest in obtaining "extra" grants for special experimental programs. A staff member of an organization that was doing little about formal evaluation or securing grants, describes the reasons for the position of the Center:

(Supervisory Clinician) Well, I think that most of the

others' experience along that line would tend to make them, in hindsight, shy away from that. We shy away from getting this six months type of grant and thereafter--find it cut out. We consider ourselves adequately funded and our thrust is not towards getting that grant for epileptics or alcoholism. . . .

A director of another center doing little in the evaluation field stated that he would accept the evaluation of a program at another organization as the equivalent to the evaluation of the same program at his own Center:

(Director) My program isn't that different. . . . Let them evaluate one program in the State and I will accept that as being applicable to mine.

A clinician with supervisory responsibilities for a program funded by NIMH in a Center that was highly involved with formal evaluation also noted a difference between centers that were "just coasting" and those that "were doing the job." However, he felt that the latter group were not being adequately rewarded for their extra efforts:

(Supervisory Clinician) The least satisfying thing is having to fool with a government that is wishy washy about what they want. They will push for something at one time and get you out there with the program and then decide that the push is off. It leaves you out there half in the program and half out. . . . This gets very frustrating because we have had to try to make this [cut in grants] up with patient fees and locally funded money and we don't get a tremendous amount of patient fees. There doesn't seem to be any reward for those centers doing the job as opposed to those just coasting.

To repeat our argument, the decision to invest heavily in evaluation is affected by the nature of the ambitions of the staff of

the organizations, particularly by key personnel such as the director and program heads. There seem to be differences among the personnel of the organizations concerning the extent to which they possess ambitions oriented toward achieving recognition beyond the confines of the local area.

Summary

The purpose of this chapter was to explore the functions that evaluation performs for the mental health organizations under study. In particular, the relationship between the organizations' struggle for existence and the decision to undertake formal evaluation was focused upon. The willingness of organizations to invest in formal evaluation was particularly interesting in view of the fact that, as we saw earlier, evaluation is not expected to have much of an impact on organizational operations. Despite the fact that most of these organizations are experiencing difficulty in finding the necessary funds to run the organizations and meet salaries, many are spending scarce resources carrying out one or more forms of formal evaluation. Is this evidence that these organizations, even under duress, can remain committed to high goal attainment rather than to pragmatic concerns of personal security and organizational survival?

To explore this and related issues, questionnaire responses

of the staff of these fourteen organizations were examined concerning what functions of evaluation they regard as most important. It was found that the functions considered most important are program evaluation, feedback, efficiency, and accountability to community. There is also a consensus that the least important functions of evaluation are the regulation of the behavior of the members of the organization and evaluation of individual performances.

Two points of particular interest were noted concerning the above responses. The views of the staff concerning the most important functions of evaluation had little relationship to the kinds of evaluation methods actually being employed by the organizations of which they are members. Current evaluation techniques are actually more appropriate to evaluation of individual clinicians (though evaluation is not used this way) than evaluation of programs, and to accountability to clientele than to accountability to community. Thus, attitudes concerning the relative importance of the functions of evaluation are not directly related to the kinds of evaluation actually undertaken by these organizations.

A second point of interest is the fact that the one function most directly associated with organizations' survival, providing justification for the funding of the mental health organization, is rated low in importance by all groups.

The data show favorable attitudes toward formal evaluation

as revealed in a series of questions concerning its worth. Likewise, the preferred functions are goal-oriented rather than directed toward such purposes as funding and control. However, it was argued that the attitudes concerning the most important functions of evaluation, and also its worth, might not accurately reflect the actual role it plays in the organizations because of limitations of the instrument measuring attitudes and also because preferences indicated on a questionnaire may not predict behavior.

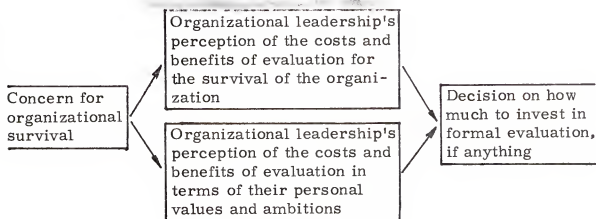
Using data acquired from interviews at fourteen organizations and extended participant observation at one Center, evidence was developed to support the following conclusions: (1) the staff of these organizations perceive a crisis in funding which has led to increased potential for tension and conflict among staff of different programs; (2) most persons interviewed, including directors, see concern for survival and the corresponding outside pressures from different levels of government as the chief impetus behind the interest in undertaking formal evaluation; (3) specifically, evaluation is being undertaken to a large degree to obtain some actual or expected benefits to the organization in its struggle for survival, such as giving the organizations a headstart on requirements for evaluation likely to be imposed in the future, justifying dollars spent on mental health organizations, obtaining or contributing to the acquisition of grants, and the use of the evaluation staff for performing non-evaluative duties.

It is suggested that organizations such as these, which are both pressed for funding and consist of highly educated individuals, seem to be particularly likely to scan the environment for any movement that can be used to advantage. It is also argued that the man-hours of work of the evaluators tend to be displaced away from evaluation toward other activities that are more closely associated with organizational survival, except in those cases where the organization had substantial slack or grants tied directly to evaluation.³⁶ Interviews and participant observation also show that the personnel of these organizations spend a considerable amount of time responding to outside requirements for data, thereby inhibiting interest in internal evaluation.

Finally, the problem of why some organizations invested heavily in formal evaluation while others did not was investigated. Evidence indicates that factors such as organizational size and financial status do not explain the differences between organizations interested in evaluation and those that are not interested. Rather, the attitudes of the directors appear to be the single most important variable affecting

³⁶ In other words, when the benefits from the evaluation are more indirect such as getting a headstart on other organizations, the evaluator is more likely to be "coopted" than when evaluation directly brings money into the organization.

the decision to invest heavily in formal evaluation in the group of fourteen organizations. The attitudes of the directors concerning evaluation appear to be the result of a complex weighing and balancing of the following components: (1) the costs and benefits of evaluation in terms of its impact on the survival of the organization as perceived by the director, (2) the intrinsic values and the nature of the ambitions of the director. The perspectives, values, and ambitions of other key personnel in the organization may also influence the decision. There seems to be a relationship between interest in formal evaluation and desire to achieve recognition beyond the local organization. Schematically, the above argument looks as follows:



Admittedly, this model of the decision process concerning investment in formal evaluation is simplified. There is undoubtedly some interaction between the director's personal goals and his perception of the costs and benefits of evaluation but it appears that both have

an independent effect on the final decision.³⁷

Some of the above conclusions can be put in hypothetical form for future testing:

(1) Evaluation activities associated with organizational survival will displace other activities which are not directly related to organizational survival.

(2) The degree of displacement of evaluation from goal-oriented objectives to survival objectives is a function of the degree of concern for organizational survival of organizational members and the number of demands made by outside agencies on these organizations.

(3) The degree to which an organization attempts to anticipate its environment is a function of the interaction between the degree of concern of the organizational members for its survival and the extent to which organizational members are capable of scanning the environment.

It is now possible to see that the relationship between the decision to undertake formal evaluation and the problem of organizational survival is much more complex than originally anticipated. The struggle for organizational survival involves the attempt to secure the necessary resources to keep the organization solvent.³⁸ The struggle for organizational survival can indeed be an obstacle to formal evaluation in organizations because it makes organizational

³⁷As noted previously, it is difficult to sort out the two factors anyway, although one fairly successful attempt is that of Neal Gross, Ward S. Mason and Alexander W. McEachern, Explorations in Role Analysis: Studies of the School Superintendency Role (New York: John Wiley and Sons, 1958).

³⁸For a description of various strategies of organizational survival, see Chapters 18 and 19 in Herbert A. Simon, Donald W. Smithburg, and Victor A. Thompson, Public Administration (New York: Alfred A. Knopf, 1950).

members, and especially the leadership, critically examine the costs of evaluation. Even when evaluators are hired, they are often likely to be displaced from purely evaluative activities to non-evaluative ones. However, ironically, it is also concern with organizational survival that has been the single greatest stimulant to undertake evaluation voluntarily in the group of organizations under study. The reason for this apparent anomaly is that undertaking formal evaluation is perceived to be potentially related to certain concrete benefits for the organization and also as a means of minimizing costs of evaluation requirements likely to be imposed in the future.

Evaluations undertaken for such reasons are likely to reflect positively on the organization. In an atmosphere characterized by tension and real concern about organizational survival, evaluations that reflect negatively on the performance of personnel, programs, or the work of the entire organization can be expected to arouse a great deal of resentment and resistance. Evaluators have generally minimized the potential costs of evaluation for organizational members by introducing evaluation in a non-threatening way and undertaking evaluations that are likely to be positive in nature.

Concerning variation among the organizations in their interest in evaluation, it was found that the differences can be explained in large degree by the attitudes of the director. Such a finding is surprising because these organizations are composed largely of professionals who pride themselves on their individualism and

autonomy. The finding reinforces the view that formal hierarchy is still an extremely important organizational variable, even in organizations which consist of individuals most likely to resist the arbitrary use of formal authority.

CHAPTER V

EVALUATION, ACCOUNTABILITY, AND RESPONSIBILITY

Evaluations are often intended to enforce responsiveness to certain values.¹ The particular method by which this is accomplished can vary from critical self-evaluations carried out by concerned groups of professionals to outside evaluations performed by the boards and funding agencies of mental health organizations.² There are also differences in the kinds of values which different evaluations emphasize. They range from standards set by societies of professionals to "popular" values held by the public, politicians, and influential groups in a community.

In Chapter I, it was pointed out that one of the major distinctions between most public and private organizations is the fact that public organizations lack the "automatic" accounting criteria of profit,

¹As noted in Chapter I, accountability is defined as the methods by which the responsiveness is achieved and responsibility refers to the actual responsiveness. However, as is discussed in this chapter, the distinction between these two concepts is not absolute because of the phenomenon of goal displacement.

²By outsider evaluation, the author is referring to any evaluation not being carried out by personnel belonging to the local organization. Some groups of outsiders, such as private psychiatrists with whom the author talked, saw evaluations by the state and national agencies as still being "insider" evaluations and not truly critical. This problem is discussed further in this chapter.

rate of return and other indices of effectiveness which are available to private, profit-making organizations.³ Thus, a tremendous body of literature has developed in the attempt to provide public organizations with the equivalent of the automatic mechanisms of the private market.⁴ In this sense, formal evaluation may be seen as the attempt to bridge the gap between the survival and goal attainment models of organizations by making the organization's survival dependent upon its performance and responsiveness to the values of those who can affect its survival.

As noted earlier, much of the literature on evaluation assumes that only evaluations by outsiders can provide a critical and objective assessment of an organization's services. Nevertheless, there are important obstacles to the effectiveness of outside evaluations as a means of achieving the desired responsiveness.⁵ In this chapter, the relationship between organizational evaluation and the issues of accountability and responsibility is analyzed.

³As noted earlier, some economists challenge the extent to which automatic evaluation actually takes place in private organizations.

⁴Thus, cults of efficiency have engulfed at one time almost every form of public organization. See, e.g., R. E. Callahan, Education and the Cult of Efficiency (Chicago: University of Chicago Press, 1962) and Carol Taylor, In Horizontal Orbit: Hospitals and the Cult of Efficiency (New York: Holt, Rhinehart, and Winston, 1970).

⁵For a general discussion of this point, see Carol H. Weiss, Evaluation Research: Methods for Assessing Program Effectiveness (Englewood Cliffs: Prentice Hall, 1972), pp. 106-123.

Comparisons are utilized between internal and external evaluations to give perspective to the problem of achieving responsibility. The focus of this dissertation is internal organizational evaluation. However, it is useful to develop the comparison between internal and external evaluations because up until now the internal evaluation of these organizations has been compared with abstract models of "critical" and "token" evaluations.⁶ Here, the extent to which internal and external evaluations are capable of providing responsiveness to values other than the sheer survival of the organization is systematically examined.

In particular, four general problem areas are examined which are important for determining the degree of responsiveness ultimately achieved by an evaluation: (1) the kinds of values held by the evaluators and the persons being evaluated; (2) the motivations behind the evaluation--their nature and strength; (3) the kinds of authority possessed and exercised by the evaluators and the reaction of those being evaluated to them; (4) the degree to which the evaluators possess the information necessary to ascertain whether the evaluation

⁶Thus, the comparisons and the criteria by which the impact of an activity such as internal evaluation is judged may in large part determine the conclusions reached. This problem makes it useful to compare "concrete" internal evaluation with actual, on-going external evaluation as another point of comparison to give perspective to the study.

is, in fact, accomplishing the desired responsiveness.

Values

The values held by the personnel of the mental health organizations, district boards, and state and national agencies are of tremendous significance for the relationship among evaluation, accountability, and responsibility. If the groups and organizations demanding and responding to demands for accountability and responsibility hold similar values, then the need for a critical outsider evaluation is likely to be less than if they hold widely divergent values.⁷ In this section of the chapter, the major values emphasized by the centers, boards, and agencies, and the degree of congruence among these values, are examined. A related issue is the priority assigned to different goals. Even if common goals can be agreed upon, there can be substantial disagreement concerning the relative importance of the different goals.⁸ A final problem is whether clear, consistent, and measurable goals exist which would enable

⁷Herbert Kaufman has made the point that early socialization to the values of the central agency often can make formal control devices unnecessary. See Herbert Kaufman, The Forest Ranger (Baltimore: The Johns Hopkins University Press, 1969), pp. 198 and passim.

⁸David Mechanic has pointed out the problem of choosing between the criteria of "need" (who is in the worst condition?) and "gain" (who is most likely to gain from help?) in the allocation of services. See David Mechanic, Public Expectations and Health Care (New York: John Wiley and Sons, 1972), pp. 227-231.

an evaluator within or outside the organization to accurately measure the degree of responsiveness achieved.

Values Within the Organizations

It was pointed out in Chapter III that there is often substantial disagreement in these organizations concerning the degree of emphasis to be placed on different kinds of services, clients, philosophies of treatment, and so forth. The basic points of agreement usually related to very broad goals such as commitment to improve mental health and decrease mental illness.⁹ Beyond extremely broad goals such as these, there is substantial disagreement existing within the mental health organizations concerning many important issues.

An example of such disagreement concerning values, orientations, and priorities occurred in the following discussion in one Center:

(Director) In response to a query by [name of a clinician interested in establishing mental health programs for children] on the problem of priorities for allocation of resources, the following are the top priorities: (1) the acutely psychotic; (2) those on medicine. . . . If the board is not concerned with children, then you should see if the citizen's advisory groups can be stirred up to demand services for children.

(Supervisory Clinician #1) I have real reservations about delivering services to children. . . .

(Supervisory Clinician #2) What will we cut out and will we

⁹One evaluator related how he had asked one program head what the goals of his program were and received the reply, "to eliminate mental illness in the county."

spread too thin if we try to provide services for children?

Later, in the same discussion, the following exchanges took place:

(Supervisory Clinician #3) I would like to change the name of the Center to the Community Counselling Service.

(Director) We are not really a counselling service. The implication would be that we were limited, and also organizations that are more directly related to medicine can get more funds.

(Planner) But the present name associates us with the State Mental Hospital and that keeps a lot of people from coming in.

(Supervisory Clinician #1) Is the question of the name of the Center a priority issue?

(Planner) It is if the name is keeping people away.

(Psychiatrist) It is clear to me that it is a question of "medical" versus "non-medical" orientations. . . .

(Supervisory Clinician #3) The real issue is what the Center is and what it is doing.

(Psychiatrist) The real issue is how we feel about ourselves and the work we are in.

(Clinician) I feel bad about what we are doing a lot of the time. . . .

(Psychiatrist) I have been in psychiatry for five years and in the last five, I haven't cured anybody. I can define cure with pneumonia but I can't here.

(Director) I feel much better in dealing with the severely disturbed. You can do something for them quickly. It takes much longer to help neurotics.

The discussion went on to other issues--for example, whether or not it was proper for mental health personnel to perform such tasks as finding jobs for clients. Some felt that it was, because other

bureaucratic agencies in the area had failed to do so, but others believed that it would be getting far afield from the major goals of the Center. The point of the above discussion is that there is no consensus as to the goals of many of these organizations once one gets beyond extremely broad generalizations.

The lack of any set of clearly defined goals and priorities has important consequences for internal and external evaluations. It increases the chance that the clinical staff will overemphasize the particular indices measured by the evaluations. Table 5.1 shows that large percentages of clinicians, directors, and evaluators foresee the likelihood of goal displacement resulting from evaluation.¹⁰ The following program head describes the effect of the emphasis of both internal and external evaluations upon the number of hours spent in the direct delivery of services:

(Supervisory Clinician) It is like the example of the teacher who knows that her children are going to take a standard achievement test and finds out what is on the test and teaches for the test. Now I know that our program is being evaluated in terms of how many hours we spend in therapy, and so I have been telling the staff, "You have to get the caseload up and get these people in for therapy." So it is a controlling factor.

¹⁰As used here, goal displacement refers to a certain kind of unintended consequence. It occurs when the person being evaluated becomes over-attached to the particular form of accounting and loses sight of the more general values (or overemphasizes one value) to which the evaluator wishes him to be responsive. In the above example, increasing the priority given to direct services is intended by the evaluators. However, if it were accomplished by so speeding up the therapy so as to result in shallow and ineffective treatment, it is likely to be regarded as goal displacement.

TABLE 5.1
GOAL DISPLACEMENT

Staff are likely to overemphasize the activities measured by evaluation.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	5.3 (2)	6.3 (1)	---
Agree	31.6 (12)	18.8 (3)	33.3 (3)
Undecided	36.8 (14)	50.0 (8)	44.4 (4)
Disagree	26.3 (10)	25.0 (4)	11.1 (1)
Strongly Disagree	---	---	11.1 (1)

*Sum of percentage figures is unequal to 100 percent because of rounding.

Another likely consequence is that the values emphasized depend to a great degree on who has control over the evaluations of personnel, programs, and organizations. Tables 5.2 and 5.3 demonstrate that a majority of clinicians agree that evaluation is likely to be used as a means of controlling and regulating the staff of the organizations.

Values of "Outsiders"

The district boards

The major points of disagreement among the personnel of the mental health centers often revolve around such issues as the best methods of treatment and priorities in the kinds of services needed.

TABLE 5.2
EVALUATION AND CONTROL: #1

Evaluation is likely to be used as a means of control over the staff.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	10.5 (4)	6.3 (1)	---
Agree	36.8 (14)	18.8 (3)	44.4 (4)
Undecided	26.3 (10)	43.8 (7)	22.2 (2)
Disagree	23.7 (9)	31.3 (5)	33.3 (3)
Strongly Disagree	2.6 (1)	---	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 5.3
EVALUATION AND CONTROL: #2

Evaluation is likely to be used to regulate the behavior of the clinical staff.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	7.9 (3)	---	---
Agree	50.0 (19)	25.0 (4)	22.2 (2)
Undecided	21.1 (8)	43.8 (7)	11.1 (2)
Disagree	15.8 (6)	31.3 (5)	55.5 (5)
Strongly Disagree	5.3 (2)	---	11.1 (1)

*Sum of percentage figures is unequal to 100 percent because of rounding.

The mental health district boards are not perceived to be concerned with the same issues. Rather, they are seen as being interested in the following concerns: (1) "dollars and cents" issues such as whether they are getting their "money's worth" of service, (2) whether they are being offered the full variety of programs and services that are potentially available, (3) the status of certain prominent statistics such as the quantity of clients served, changes in inpatient and mental hospital loads, and similar statistics. The interests of the district boards are characterized by persons in the mental health fields as follows:

(Director #1) It [the district board] is saying, "What are the services being offered?" and that is a very valid question. It is the equivalent in business of the profit for the year. If you want to call it evaluation, you can, and I think that the board should evaluate that.

(Director #2) We had preliminary hearings for the county a week ago and that is one of the things they are asking, "What are you doing for the money we are giving you?" and "How many people do you serve?" and "After you serve them, how many are back on their jobs?" and "How many are in the state hospitals?"

(State Official) The boards feel a tremendous responsibility for the expenditure of funds and don't know where to get the information to answer the questions. They are feeling politically weak.

While people within the organizations see a potential overemphasis on questions of money and quantity, nevertheless these values are recognized by most organizational members as being legitimate concerns to which they should be responsive.

Other values held by members of the district boards and influential members of the communities in which they are located are actively opposed by some members of the mental health organizations. One psychiatrist cynically observed that if their organization was to get more support from the community for its programs, it would have to show that better mental health would lead rural farm workers "to pick more beans." The director of a Center describes the relationship between his own values and those of the community:

(Director) Again, every community is different. One of the dominant values of this community is a bias against negroes. I disagree with this and have to try to change it, which is a very difficult and long-term thing. Also, some people don't want to or aren't particularly interested in curing alcoholism because then they don't think that they would have the people to pick the oranges. The point is that the community often evaluates services according to their own values, which I myself often disagree with.

Some members of mental health organizations are even skeptical concerning whether the communities are truly interested in thrift and efficiency of services delivered. The director of programs in a certain area thinks that the community's "evaluation" of the organization is based upon the amount of money and jobs brought into the community by the Center. He expects there to be a likelihood of a loss of support for the Center when the contributions from the state and national government decrease. In the following discussion a psychiatrist argues that sheriffs in the local communities would use a new law on alcoholism to their own advantage with a resulting

burden for the Center.¹¹

(Supervisory Clinician) Won't the sheriffs know who to admit and who not to admit?

(Psychiatrist) The sheriffs will have the incentive to put everyone in the hospital and keep them there and let the Center pay for it.

In short, there are many instances in which the values of the personnel of the mental health organizations may conflict with the values of the members of the district boards or influential persons in the communities. In such cases, internal evaluation is not likely to make the organizations responsive to the values of the communities. Indeed, the values encouraged by internal evaluation may be directly opposed to those desired by the outside community.¹²

The agencies

Generally, the values of the personnel of the state and national agencies are perceived to be relatively similar to those of the members of the local mental health organizations. Yet, the state and national laws concerning mental health do not clearly specify

¹¹The law requires that the alcoholics be treated rather than jailed.

¹²An interesting example of the ambivalence of many people toward the issue of "community participation" and control occurred recently when members of the same group that had encouraged greater local participation in mental health centers took a position against having a review committee concerning sterilization because it would be "too subject to local influence." See Judith Coburn, "Sterilization Regulations: Debate Not Quelled by HEW Documents," Science, March 8, 1974, pp. 935-938.

operational goals by which the effectiveness of mental health services can be measured. Two directors describe the limitations of the state laws as far as determining quality and efficiency are concerned:

(Director #1) Well, in this instance, it [an evaluation] was just to see if the law was being implemented or not--whether the services were being provided. The Baker Act says nothing about the quality of service.¹³

(Director #2) What has happened is that they [the state agency] won't even let us charge for our own psychiatrist. A private psychiatrist can be charged for and it makes no difference to the state. They will fund him because it meets their criteria of funding, even if it costs more.

The problem is that the statutes concerning mental health do not define quality, effectiveness, or efficiency. They are mainly concerned with "intermediate goals" such as "integration of services," "a unified mental health system," "participation by local governments," and the "establishment of a uniform ratio of state and local participation."¹⁴ In the absence of clearly defined "end goals," such intermediate goals tend to become ends in themselves. Thus integration of services or uniformity of ratios of participation are likely to be rewarded whether or not they actually lead to increased effectiveness of the services offered.

¹³The Baker Act is the name applied to legislation related to the funding of mental health centers in Florida.

¹⁴See Florida, Florida Statutes (1971), c. 394.66.

Much the same is true with respect to the national agency (NIMH) and its goals. At its inception, three especially important priorities characterized the movement toward community mental health: (1) an emphasis on local treatment with a related decrease in the size and importance of large state mental hospitals, (2) emphasis on comprehensiveness and continuity of care in the programs and services being offered, (3) much more emphasis on prevention through such services as education and consultation.

While none of these priorities has been abandoned, the limitations of each have become apparent. Emphasis on treatment in the community and decreased size of mental hospitals can greatly increase the recidivism rate and often put a strain on the client's family.¹⁵ In one Center, a clinician suggests that the refusal of the head of the inpatient program to accept many of his patients prevented the personnel from spending adequate time on services other than aftercare:

(Supervisory Clinician) Our figures on inpatient care may look great, but we have to spend 50 percent of our time on aftercare [for the patients whom they wished to have admitted into inpatient care].

¹⁵ A long and continuing debate has occurred concerning the relative costs and advantages of maintaining patients in the community. See, e.g., George Fairweather et al., Community Life for the Mentally Ill: An Alternative to Institutional Care (Chicago: Aldine Publishing Company, 1969), pp. 3-7 and Mervyn Susser, Community Psychiatry (New York: Random House, 1968), pp. 16-17.

Some directors question the goal of sharply decreasing state mental hospital patient loads:

(Director #1) It is cheaper to keep him in the State Hospital than in the communities because the communities don't have any facilities for them and there is no more shining example than [name of the location of the Center]. We are absolutely swamped. We couldn't begin to handle people from our area at [who are presently at] the State Hospital. It is a damn good political argument to talk about getting them back in to the community but what are you going to do with them once you get them there?

(Director #2) I don't believe in this nonsense of phasing out state hospitals and creating small state hospitals at the community level. I think that that is stupid. Some patients are better off at the State Hospital.

Even the concept of continuity of care has been challenged as being irrelevant if the quality of care is not good.¹⁶

Although it was the national agency (NIMH) which had strongly emphasized the need to deal with prevention, its most recent forms of "accountability" have rewarded institutions that have a large number of direct encounters. At a meeting attended by local mental health center personnel, an official from NIMH humorously referred to the latest form required to be filled out by the local organizations. He admitted the new form would make it seem as though the entire emphasis of NIMH was changing away from prevention and indirect

¹⁶Thus, at a meeting attended by the author, an NIMH official argued that it was possible that a "discontinuity of treatment" might be beneficial in certain cases if the client has been receiving inappropriate treatment.

services:

(NIMH Official) You are going to be getting something from our office. It is a form and it has to be filled out. You are going to feel--and this is true--that we are changing our entire emphasis. The cost per client will be asked for.

According to some directors who received the form, the cost per patient is defined in such a way as to exclude indirect services.

Summary of Values

Beyond very general goals, there is a lack of clearly defined measures of the quality and efficiency of services delivered by mental health organizations. As a consequence, there is a distinct danger of goal displacement due to the overemphasis upon the particular criteria stressed in evaluations. The values and priorities of those highest in the hierarchy also tend to be emphasized at the expense of the values and priorities of those with less power.

District boards tend to be interested in a few highly visible criteria by which they judge the performance of mental health centers. These criteria include "dollars and cents items," certain quantitative indices, and the variety of services being offered by the mental health centers. Members of the mental health centers (including its evaluators) sometimes disagree with the certain values held by the boards and do not wish to be responsive to them. In cases when internal and external value systems diverge greatly, internal and external evaluations may come to different conclusions

concerning the performance of the mental health centers.

The state and national agencies also lack clearly defined goals and priorities. Personnel of the local centers examine carefully the particular criteria of funding and the nature of the data requested by these agencies in order to have an indication of what values and priorities are in current favor and likely to be rewarded.

The degree of responsiveness which an evaluator (internal or external) is able to achieve is affected by the following factors related to the issues discussed above: (1) the extent to which the "end" goals and priorities favored by the evaluator can be clearly defined and measured,¹⁷ (2) the extent to which the persons being evaluated agree with the goals and priorities of the evaluator, (3) the amount of unanticipated displacement that occurs as a result of the evaluation. Thus, an evaluator is likely to achieve the kinds of responsiveness he desires if he can clearly measure his goals, if the people he is evaluating agree with these values, and if he is able to design an evaluative instrument that avoids the problem of goal displacement.

¹⁷ The reasons for the lack of clarity of "end goals" may result from several factors. One such factor is simply an ignorance or uncertainty about what goals should be. Another argument is that the obscurity of goals may be the result of compromises among different individuals or groups in an organization. For the latter point of view, see Charles Lindblom, "The Science of Muddling Through," Public Administration Review, Vol. 19 (Spring, 1959), pp. 79-88.

Motivation

The Motivation of "Outsiders"

People may have similar value systems but differ greatly in the extent to which they are motivated to achieve responsiveness to these values. Persons outside of the organizations do not have to worry about internal concerns with organizational survival but can afford to be highly critical in their evaluations. Indeed, it has been argued that persons evaluating from the outside are "null hypothesis oriented" and eager to discover faults or problems in the services they are evaluating:

The independent evaluator has a vested interest in showing that there was a need for the evaluation in the first place and that the cost of the evaluation was justified by the savings that can be made in the program. Also, the evaluator is aware of the greater drama and newsworthiness in findings that start with, "Surprisingly, the program results are the exactly opposite of that sought."¹⁸

As was noted in the last chapter, there is a general perception among the directors of mental health organizations of an increased tendency of district boards and funding agencies to demand proof of the worth of mental health services. In fact, many of the personnel perceive what they believe to be a constant mistrust and pressure from

¹⁸Selma J. Mushkin, "Evaluations: Use with Caution," Evaluation Vol. 1, No. 2 (1973), p. 34.

these "outsiders," as does the following director:

(Director) There is a general orientation that we are trying to hide something from them.

A state official who is unusually sympathetic to the situation of the local mental health organizations describes how most people working in the state agencies have a general outlook of attempting to catch the "cheaters":

(State Official) People who are out to get the cheaters are always around and they tend to win the arguments [in the state agency] in the long run.

However, there are constraints on the extent to which outsiders are motivated to evaluate the way that local centers are using public funds. Much of the interest of members of the communities in evaluation is seen by the personnel in the organizations as being inspired by the political benefits which they think can be derived from it.¹⁹ Carrying out an evaluation takes time and money which many members of the community (including members of the district boards) are not willing or able to invest.²⁰ However, the evaluations which they do carry out are of a potentially critical (and negative)

¹⁹ Political and professional interests and approaches to health and mental health tend to be quite different. See, e.g., Herbert Kaufman, "The Politics of Health Planning," American Journal of Public Health, Vol. 59 (May, 1965), pp. 795-796.

²⁰ Members of other mental health organizations have noted the negative impact of the costs of participation on community involvement. See, e.g., Seymour R. Kaplan and Melvin Roman, The Organization and Delivery of Mental Health Services in the Ghetto (New York: Praeger, 1973), p. 104.

nature because they are not limited by the survival concerns of the organization.²¹

The Motivation of Insiders

Internal evaluation and accountability

Outsiders appear to be motivated to evaluate mainly by the desire to achieve accountability and ultimately responsibility to concerns such as whether they are getting their money's worth of services. By way of contrast, questionnaire data was presented in the last chapter which showed that neither accountability to community nor accountability to clientele is ranked as being the most important function of evaluation by organizational members. Internal uses of evaluation, such as evaluation for the purposes of feedback and program evaluation, are preferred by people within the organization.²²

Additional questions were asked related to accountability. The

²¹Of course, many community and district board members strongly support funding for the programs of the mental health centers. The point is that they are not limited by the survival concerns of the organization.

²²As noted previously, these functions of evaluation are not necessarily mutually exclusive. Program evaluation simply refers to evaluation in which the program is the unit of analysis. However, the preference of internal organizational members for feedback and program evaluation over accountability reveals a difference in the emphasis of the evaluation.

responses show a strong support for the use of internal evaluation to achieve accountability to the community and clientele of the mental health organization. Tables 5.4 and 5.5 show that over 80 and 70 percent of clinicians respectively support the use of internal evaluation to determine the funding of the mental health organizations and to achieve a greater degree of community control, support drops to 57 and 47 percent respectively among clinicians as revealed in Tables 5.6 and 5.7. It should be noted that Table 5.7 shows that more directors oppose the use of evaluation for increased community control than support it. This is significant in view of the fact that they are the ones who usually report directly to the district boards. As was pointed out in Chapter III, the personnel of the organizations show strong support for broad evaluations but are less enthusiastic when the potential threats resulting from an evaluation are evident.

The above data suggest that evaluators, clinicians, and directors do not regard evaluation for the purpose of accountability to be the most important reason for undertaking evaluation but prefer internal uses of evaluation. A basic factor which limits the kinds of information with which they are willing to provide the outside community is the need to protect the organization from danger (e.g., decline in funds, a bad press, and so forth). Directors and other personnel of the organizations feel it is important to present only positive information concerning their organization to the community:

TABLE 5.4
ACCOUNTABILITY TO COMMUNITY

Evaluation can and should be used to provide accountability of the mental health organization to the community it serves.

Response	Percentage of Clinicians*	Percentage of Directors	Percentage of Evaluators*
Strongly Agree	15.8 (6)	37.5 (6)	44.4 (4)
Agree	71.1 (27)	37.5 (6)	55.5 (5)
Undecided	5.3 (2)	12.5 (2)	---
Disagree	7.9 (3)	12.5 (2)	---
Strongly Disagree	---	---	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 5.5
ACCOUNTABILITY TO CLIENTELE

Evaluation can and should be used to provide the accountability of the clinical staff to the clientele of the mental health organization.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	15.8 (6)	25.0 (4)	22.2 (2)
Agree	57.9 (22)	50.0 (8)	55.5 (5)
Undecided	15.8 (6)	6.3 (1)	11.1 (1)
Disagree	5.3 (2)	12.5 (2)	11.1 (1)
Strongly Disagree	5.3 (2)	6.3 (1)	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 5.6
EVALUATION FOR FUNDING

Evaluation can and should be used to determine how much funding mental health organizations should receive.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	23.7 (9)	6.3 (1)	22.2 (2)
Agree	34.2 (13)	31.3 (5)	44.4 (4)
Undecided	23.7 (9)	31.3 (5)	11.1 (1)
Disagree	18.4 (7)	31.3 (5)	22.2 (2)
Strongly Disagree	---	---	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 5.7
EVALUATION FOR COMMUNITY CONTROL

Community control over mental health services can and should be increased through the use of evaluation.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	2.6 (1)	6.3 (1)	22.2 (2)
Agree	44.7 (17)	31.3 (5)	22.2 (2)
Undecided	28.9 (11)	12.5 (2)	33.3 (3)
Disagree	21.1 (8)	37.5 (6)	22.2 (2)
Strongly Disagree	2.6 (1)	12.5 (2)	---

*Sum of percentage figures is unequal to 100 percent because of rounding.

(Director) I rather doubt that most people in the community can use data effectively and I imagine that accountability to the community will still have some flowery frills involved, and there will not be much emphasis placed on negative components of an evaluative study. It would apparently be un-American to do so. You need salesmanship--selling your strong points and not talking about your weak points. That is American culture, you know. It is actually a sign of strength to display your weaknesses but that would be un-American. Certainly, it is going to be slanted any time you need public relations.

Thus, the kinds of information which these organizations are willing to provide voluntarily to the community or other outsiders is limited by their perception of the need to present a "good face" to the funding agencies and district boards.

Does this mean that the centers are unresponsive to the values of the community? Are the organizations less critical in their evaluations of the services they provide than the outside agencies and boards are? Most of the organizations are undertaking formal evaluation which opens them up to feedback and evaluation by their clientele through the use of goal attainment scaling, consumer satisfaction surveys, and needs assessment surveys. Of course, as pointed out earlier, these evaluations are expected to be positive and are carried out to a great extent with a view to supporting the survival of the organization.

Nevertheless, insofar as the staff took the information derived from these evaluations into account in the delivery of their services, these internal evaluations would have the effect of making the personnel

of the organizations responsive (to a certain extent) to the values of some members of the community--the clientele.²³ Also, the reason why the evaluations are likely to be positive is due more to their nature than to any overt manipulation by the organizational personnel.

Professionalism and evaluation

While it was argued in the last chapter that much of the basis of interest in formal evaluation is related to the concern for organizational survival, there are other sources of motivation which can potentially foster the desire to evaluate the activities and services carried out by the mental health organizations. The issue of professionalism is relevant here because these organizations are composed substantially of professionals such as clinical psychologists, psychiatrists, and psychiatric social workers, among others.

Two lines of argument have been developed concerning the relationship between professionalism and evaluation. On the one hand, professionalism has recently been seen as an obstacle to evaluation because neither professional self-evaluation nor evaluation by professional colleagues has been effective in controlling the quality of professional services.²⁴ On the other hand, the traditional argument

²³"Community" is an extremely difficult term to define. The directors tended to associate the "community" with the district boards.

²⁴See Elliot Freidson, Professional Dominance (New York: Atherton, 1970).

is that professionals do internalize values concerning correct practices and quality of service during their education and training which they carry over into their practice.²⁵

In regard to the first point of view, data from questionnaires was presented in Chapter III which shows that clinicians and directors perceive professionalism to be the least important of five obstacles to formalized evaluation. Nor did the evaluators see professionalism as being a particularly important obstacle. They rate the lack of resources for evaluation, skepticism concerning the technology of evaluation, and anxiety concerning the way that evaluation may be used as being more important obstacles to the effective implementation of an evaluation program.²⁶

Two additional questions were asked related to the issue of professionalism and formal evaluation. Table 5.8 shows that clinicians, directors, and evaluators reject the position that staff members are capable of evaluating their own performance. However, Table 5.9 shows more uncertainty in regard to this point.

²⁵Herbert Simon argues that the professionalization of the federal bureaucracy has led to increased quality of service and less corruption. See Herbert A. Simon, "The Changing Theory and Changing Practice of Public Administration," in Contemporary Political Science: Towards Empirical Theory, ed. Ithiel de Sola Pool (New York: McGraw-Hill Book Company, 1967), pp. 86-120.

²⁶It should be noted that the questionnaire referred specifically to internal evaluation and not outsider evaluation.

TABLE 5.8

PROFESSIONALISM

Professional clinical staff members are capable of evaluating their own performance without the aid of a formal evaluation by an evaluator.

Response	Percentage of Clinicians*	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	---	---	---
Agree	28.9 (11)	12.5 (2)	---
Undecided	23.7 (9)	25.0 (4)	11.1 (1)
Disagree	44.7 (17)	43.8 (7)	55.5 (5)
Strongly Disagree	2.6 (1)	18.8 (3)	33.3 (3)

*Sum of percentage figures is unequal to 100 percent because of rounding.

TABLE 5.9

CLINICAL SELF-EVALUATION

Only the clinical staff involved in direct services can actually judge whether or not programs are successful.

Response	Percentage of Clinicians	Percentage of Directors*	Percentage of Evaluators*
Strongly Agree	5.3 (2)	6.3 (1)	---
Agree	31.6 (12)	18.8 (3)	33.3 (3)
Undecided	36.8 (14)	50.0 (8)	44.4 (4)
Disagree	26.3 (10)	25.0 (4)	11.1 (1)
Strongly Disagree	---	---	11.1 (1)

*Sum of percentage figures is unequal to 100 percent because of rounding.

Interviews and participant observation indicate that many of the professionals working in these organizations do believe in what one called the "professional assumption" that they can manage themselves. For these personnel, the acceptance of formal evaluation by inside or outside evaluators is based more upon practical necessity than anything else. The following director and supervisory clinician took this point of view:

(Supervisory Clinician) It is probably true [the argument about professionals being able to evaluate themselves] but I don't think that there is any way that you can sell that to the community. They would say, "These are queer birds. They don't have any way of measuring what they are doing."

(Director) Sure, it is prevalent. Most professionals feel that as a component of their professional abilities or stature they should be given what is called a professional assumption that they will manage themselves within a professional code of ethics, that they will use their time reasonably efficiently and competently. . . . The problem is that if we are going to continue to receive public funds, we have to make some kinds of attempts to evaluate ourselves.

There does not appear, then, to be strong resistance to the idea of formal evaluation by inside or outside evaluators on the basis of the argument that such evaluation is unnecessary because professionals can and do evaluate themselves. However, it is not clear to what extent this acceptance of formal evaluation is based upon a belief for such evaluation or the pragmatic acceptance of formal evaluation because it is necessary to obtain public funds.

Critical internal evaluation

The above discussion leaves unanswered the question of whether

professional training leads these professionals to actually carry out critical self-evaluations or evaluations of other programs and personnel within the organizations. Also, are there any other sources of motivation for critical evaluation within the organization?

Close observation of one Center and interviews with personnel at other organizations brought to light several examples of clinicians making highly critical judgments about the quality of personnel and programs within the organizations of which they are members. However, these judgments are generally of informal and subjective types of "evaluation" similar to those described in Chapter III.²⁷ For example, a program head admitted to other staff members of the Center that the program he headed was of doubtful quality and represented "band aid" treatment. In another case, a director of a program stated to other program heads that his own staff had had only one productive day since he had taken charge of the program. At another Center, the director describes how he is attempting to get his own answers to questions related to effectiveness aside from the information required by the State:

(Director) We want to get the answers to these questions. I think that we are hungry for them which is the reason why we are going to spend what to me is a lot of money on this computer firm just so we will basically know what is going on, what kind of dropout rate we have, what is our success in various programs. . .

²⁷In Chapter III, it was found that the most common form of evaluation is informal and subjective. Here, the motivations behind this form of evaluation are analyzed.

Certain types of informal, critical judgments tend to be more common than others in the organization where participant observation was carried out. In particular, the supervisory staff spend a great deal of time discussing the quality of the performance of those lower in the hierarchy than themselves. They discuss how to evaluate nonprofessional staff in the organization and provide them with the incentive to perform better. The director of the organization remarks on this tendency to focus evaluative judgments on lower level personnel in the organization but his point is not taken up by others present:²⁸

(Supervisory Clinician #1) In line with evaluation, we are trying to take a look at each of our clients and see what we can do. . . . What is their potential?

(Director) How do we evaluate ourselves? It is comforting to talk about the paraprofessionals on the staff. . . .

(Supervisory Clinician #2) I would like to deal with the issue of consolidation.

Another type of highly critical, informal evaluation involves negative statements made by the personnel of one program concerning the quality and effort of other programs. An example occurs in the following discussion as to whether locally based programs should provide their own "replica" of services heretofore provided only at the central location of the organization.

²⁸Of course, lower level personnel also evaluate their superiors but their judgments tend to focus on factors such as the degree of protection which the head provides to the organization and members of their own program. See Herbert A. Simon, Donald W. Smithburg, and Victor A. Thompson, Public Administration (New York: Alfred A. Knopf, 1950), p. 409.

(Supervisory Clinician #1) We don't look at the problem of quality. Is there a feeling that we can't cut out any programs?

(Supervisory Clinician #2) I think that there is a lot of competition going on and they are trying to deliver services but can't furnish the quality.

(Supervisory Clinician #3) The question is how much community based service we are going to have.

In another example, the head of programs in a certain area is arguing that he and his staff involved in the direct delivery of service carry a heavier load than the administrative staff (including the evaluators) and consultants in the organization:

(Supervisory Clinician) I do the work on getting local grants funded on my own.

(Evaluator) My staff would do this if you made it a priority.

(Supervisory Clinician) You could assist me but I would have to put in so much input myself, that when it came down to it, it would fall on me.

(Director) There seems to be an atmosphere that, "I am working hard but somewhere else someone is goofing off." This seems to be prevalent.

Still another source of motivation for informal, critical evaluation is the situation in which personnel within the organization disagree with the organizational "philosophy of treatment" or even have doubts about the worth of its services. Some directors admit to feeling that private practitioners could provide better quality and more quantity of direct service for a similar cost. The following director takes this point of view:

(Director) Well, I will give you an example. In . . . region [one of the areas served by the Center], they have a budget of x dollars. A clinician here should see at least twenty-five hours of direct therapy, but a professional in private practice sees patients for about thirty-four hours. . . . I am not talking about indirect services. . . but you are paying [figure concerning the number of dollars spent by the organization in this region] and it seems to me that a psychiatrist could serve that population as well or maybe better.²⁹

The high rate of turnover in the position of director (often held by psychiatrists) may have been due in part to the rejection by directors, and particularly psychiatrists, of the values and worth of the mental health center movement.³⁰ Disagreement with the values and worth of an organization makes possible a much more critical perspective than normally would be expected of an organizational member.

A final source of motivation to evaluate critically the services of the organization is ambition on the part of members of the organization, particularly the evaluators. The following evaluator admits to seeing his major avenue of career development to be at the state level rather than within the organization. He welcomes the possibility of the state agency expanding its evaluation of local mental health centers:

²⁹It appeared that the same directors who were skeptical of the quality of the services of the mental health centers also tended to be doubtful of the worth of indirect services.

³⁰Many directors feel that they have lower status after leaving private practice to become heads of these organizations. See H. G. Whittington, "Community Mental Health Services in Kansas: Personal Value Systems and Mental Health," American Journal of Public Health, Vol. 55 (January, 1965), pp. 33-37.

(Evaluator) Praise the Lord. I think it is definitely possible [i.e., setting up an expanded state evaluation system] and I hope I can be part of it. . . . I think that if they [the state agency] bring in a group of evaluators or people who have had experience in evaluation, a group like this would probably come up with some reasonable methodology. . . . It would require an increased audit by the State and a common records system.

In short, individuals who nominally are members of the organization can remain quite detached from it due to personal ambitions or disagreement with the organization's philosophy.

Summary of Motivation

An evaluator must be motivated in order to achieve responsiveness to the values and priorities which he desires to emphasize. Outsiders and insiders tend to have different kinds of motivation behind their evaluations. Outsiders do not have to worry about the survival of the organization. They tend to favor what is called a "summative evaluation" in which the purpose is to render a single judgment on the services of the organization.³¹ Their major constraints are time and money with which to carry out the evaluation.

Inside evaluators are usually limited by attachment to organizational

³¹For a discussion of the difference between summative and formative evaluations, see Jacqueline Kosecoff and Carol Fitzgibbon, "Many a Slip," Evaluation Comment, Vol. 4 (December, 1973), pp. 6-8. The latter refers to evaluation which has the purpose of improving programs, personnel, and organizations rather than of rendering final judgment on them.

survival. They prefer to use evaluation for internal purposes, such as feedback, to improve programs and services. This type of analysis is called "formative evaluation." Thus, organizations do not appear willing to present information voluntarily to outside agencies or district boards which would reflect unfavorably on the performance of the organization and its personnel. Consequently, the degree to which internal evaluation provides the "functional equivalent" of outside evaluation depends upon the extent to which there is a congruence between internal and external value systems.

Despite the limits imposed by concern with organizational survival, critical judgments do take place within the organizations under study. However, they are generally based on an informal and subjective type of assessment. The basis of the motivation for critical evaluation includes values internalized through general education and professional training. Other sources of motivation for critical evaluation include personal ambition and disagreement with the values of the organization. Organizational members are also generally more critical of persons who are either members of different programs or lower in the hierarchy than themselves.

Authority

It has already been described how it is necessary for an evaluator to be able to identify and measure his goals in order to

achieve responsiveness to them. He must also possess the motivation to gain responsiveness to his values. A third factor which is important in determining the amount of responsiveness secured by the evaluator is the amount and kinds of authority which he exercises. Authority may be defined as the "ability to evoke compliance in others."³² Broadly defined, there are several potential bases of authority, including authority of position, authority of competence, and authority of person.³³

What are the resources of an evaluator that could make the rest of the staff responsive to him? Based on a search of the literature on evaluation and information from participant observation and interviews, five factors were selected which are potentially important in determining the effectiveness of the evaluator.³⁴

³²See Robert Presthus, "Authority in Organizations," Public Administration Review, Vol. 20 (Spring, 1960), pp. 86-91.

³³See Robert L. Peabody, Organizational Authority (New York: Atherton, 1964). Authority of competence can include both competence learned through formal education and competence acquired by experience. Authority of person can include relationships with different groups such as clinicians and directors of the organizations.

³⁴Relating these five factors used in the questionnaire to the three types of authority derived from Peabody, "the respect of the clinical staff for the evaluator's technical skills and knowledge" and "formal role and powers" are the equivalent of authority of competence and authority of position. The evaluators' relationships with the clinical staff and director of the organization may both be considered subtypes of "authority of the person."

Clinicians, evaluators, and directors were asked to rank the importance of these five factors and a rough index of their importance was formed as described in Table 5.10. There is a general consensus as to the order of importance of the different functions among all three groups of respondents. The evaluator's technical competence and support from the head of the organization are clearly regarded as the two most important of the five factors listed.³⁵

The evaluator's contribution to "non-evaluative" activities is regarded as being least important of the five factors. The evaluator's formal powers and friendships with the clinical staff are regarded as being somewhat less important than the respect of the clinical staff for his technical competence and relationship to the director.

Authority of Competence

As noted earlier, the technology of evaluation is seen as needing further development but is not generally considered to be an insuperable obstacle to successful evaluation. Interviews and participant observation confirm that the perception of the evaluator's

³⁵It should be noted that the questionnaire refers to the "respect" of the clinical staff for the evaluator's competence rather than "objective" competence.

TABLE 5.10
THE RESOURCES OF AN EVALUATOR

Please rank the following in what you regard to be their order of importance in enabling an evaluator to establish an effective evaluation program. (1 = the most important; 5 = the least important).

- #1 The evaluator's formal role and powers in the organization.
- #2 The evaluator's personal friendships and relationships with the clinical staff.
- #3 The respect of the clinical staff for the evaluator's technical skills and knowledge.
- #4 The evaluator's relationships with and support from the head of the mental health organization.
- #5 The evaluator's contributions to "non-evaluative" aspects of his job such as data collection, grant writing, and administration.

The following index was formed by scoring five points for each time that a factor was ranked as being the most important, four points for the next most important, etc.

Clinicians		Directors		Evaluators	
Number	Points	Number	Points	Number	Points
3	152	3	63	3	37
4	111	4	56	4	30
1	101	2	36	1	27
2	101	1	36	2	24
5	80	5	34	5	16

competence by the clinical staff and director is a necessary pre-condition for his effectiveness. One evaluator admits that he wishes he had a "bigger bag of tricks," and that his biggest flaw is a lack of time to explore the literature of evaluation:

(Evaluator) The biggest flaw that I see in what I am able to do is that I have not yet had the opportunity to completely explore the literature, that I have not had the opportunity to develop to my satisfaction a sufficient inventory of methods. . . and that is my concern--that I have a very broad knowledge and a very good bag of tricks.

However, evaluators tend to be skeptical of the ability of most of the clinical staff to judge their knowledge and abilities in the evaluation field. The following evaluator expresses himself on what he considers to be their lack of sophistication concerning statistical techniques:

(Evaluator) Well, the problem is that a lot of clinicians--and also the non-clinical people who hire you--don't really understand a sophisticated data analysis. So, if you give them a report that is in terms of the number of people handled and percentages of clients who say, "Gee, that was really peachy,"--that is something that is readily intelligible to them. And they can go to their board. . . and say, "Look, isn't this nice? Everyone thinks we are so wonderful. We handled so many clients. . . ." I bet that when I start feeding variables in and doing something like a discriminant analysis that there are not more than one or two people over there who would know about that. . . .³⁶

³⁶A discriminant analysis is a multivariate technique in which the independent variables are used to predict which of two or more mutually exclusive categories the cases will "fit into." See Francis J. Kelley, Donald Beggs, and Keith A. McNeil, Research Design in the Behavioral Sciences: Multiple Regression Approach (Carbondale and Edwardsville: Southern Illinois University Press, 1969), pp. 234-240.

In addition to having evaluators with competent technical ability and knowledge, clinicians also favor persons with clinical knowledge and experience. In one organization, the director was discussing the possibility of giving the evaluator some "line authority" and thus ability to make substantive decisions concerning the programs. Some clinicians objected because, they said, the evaluator had no "clinical experience" or "clinical appreciation":

(Supervisory Clinician) What are you talking about? [concerning the evaluator's proposed new responsibilities], . . . putting him in a staff or line position?

(Director) For example, I would go out and work in the clinical area and talk about programs, not about dollars and cents, planning, or effectiveness.

(Supervisory Clinician) I am opposed to that and part of the problem is that [name of the evaluator] has had no clinical experience. . . . He has no clinical appreciation.

Given the choice, all clinicians interviewed agree that they would prefer someone with clinical experience as an evaluator. Several point out that such individuals are hard to find:

(Supervisory Clinician) But you really need somebody who knows research design, and most good clinicians that I know don't know or don't like research and development. I don't know why but they seem to be mutually exclusive.

One evaluator (without clinical experience or background) sees the argument concerning clinical experience as merely a legitimating factor in overcoming resistance to the conclusions of the evaluator:

(Evaluator) Clinical skills do help and clinical credentials do help. It is because you become more legitimate, and it is very easy for people to point to you and say, "Well, we don't have to listen to him because he isn't a clinician. . . ."

The perception of competence and knowledge can be more important than their actual possession. An evaluator who had a doctoral degree in psychology said that the clinicians in the organization assume that he has knowledge concerning the clinical field because his degree is in psychology. However, he actually did not have this experience.³⁷ Earlier, it was pointed out that program directors and personnel prefer to have an evaluator who comes and "lives with their program" and thus sees its problems and limitations. Generally, it appears that clinicians prefer to have someone evaluating them who shares as closely as possible their own background, knowledge, and general perspective.

Authority of Position

Responses to the questionnaire indicate that formal authority associated with the position of the evaluator is not nearly as important as the evaluator's relationship with the head of the mental health organization. This finding is not surprising because, as was pointed out in Chapter IV, it is the director of the mental health center who

³⁷ The disciplines and backgrounds of the evaluators were varied, including clinical psychology, education, systems analysis, sociology, and social work.

largely determines whether to invest in an evaluator and formal evaluation.

The actual structure of these organizations varies considerably despite the fact that they offer the same basic core of services. In many organizations the evaluator and his staff are regarded as nominally "co-equal," in terms of formal authority, with the program heads and staff of other programs. However, the amount of resources devoted to evaluation is usually relatively small in comparison with the other service programs. Thus most evaluators did not perceive their status to be the equivalent of that of the other program heads.

The importance attached to the evaluator's particular relationship with the head of the organization is especially significant because there is a large turnover in the latter position.³⁸ A change in the director of the organization can in large part determine whether an evaluator will be effective in his role.

Authority of the Person

In our above discussion concerning positional authority, it was noted the evaluator must develop a good relationship with the director in order to be effective. The two other factors associated

³⁸ During the first six months of this study, four of the directorships of the fourteen organizations under study either were already vacant or became vacant.

with authority of the person--the evaluator's personal relationships with the clinical staff and his contributions to non-evaluative activities--are less important.³⁹ Nevertheless, interviews and participant observation indicate that substantial importance is attached to these two factors by both evaluators and clinicians.

Introducing evaluation by beginning with non-threatening types of evaluation and securing the participation of the clinical staff are two of the major strategies used by evaluators:⁴⁰

(Evaluator) You have probably heard in the past that they experienced problems in research and evaluation and couldn't get the staff to do this and that. The thing that I think that has enabled us to get past that is to do a study that is in no way threatening to the staff. They could care less. When they saw that I was a fairly decent guy, that I wasn't out to be a threat to them. . . . They would say, "Maybe he has got something to offer us."

The director of the organization in which the above evaluator operates agrees with this method of introducing evaluation:

(Director) It wasn't planned this way but I think that

³⁹As used here, "authority of person" refers to differences among individuals in their ability to secure compliance from others which is not dependent on the particular position which the individuals hold or on their technical competence. While nominally called authority of person, it depends not only on his personality but also his ability to develop relationships with others.

⁴⁰Introducing evaluation has often created problems of resistance. See, e.g., Richard H. Blum and Joseph J. Downing, "Staff Response to Innovation in a Mental Health Service, American Journal of Public Health, Vol. 54 (August, 1964), pp. 1230-1240.

bringing in a research and evaluation staff to do a needs assessment study first is a real plus because we are not evaluating anyone but the community. . . . If he had come on board and immediately talked to the staff on how we are going to evaluate programs he might have received a very different reception. . . .

Personality and interpersonal relationships are important factors in determining the effectiveness of role performance by individuals in organizations.⁴¹ Some argue that these two factors are especially important in organizations composed of clinicians.⁴² Certainly, the evaluators are quick to admit their importance:

(Evaluator #1) I would argue that the informal networks are much more important in a place like this than the more formal. This is probably true in most organizations but here it is even more so because of the types of disciplines represented. The military operates on informal relationships but breaks these down every so often by moving people around.

(Evaluator #2) No matter how talented you are, no matter how much money you get, and how much you know about research-- if the people don't trust you enough in order to cooperate with you, then you can't do anything. They have to cooperate. They have to want what you have to offer. We operate in response to ongoing situations, and if we can't get them to go along with us or to feel a need of what we have to offer then we are no good at all. . . .

(Evaluator #3) Without the ability to develop good interpersonal relationships, you just don't pull off an evaluation program. This is essential--to get cooperation on their part.

⁴¹ See Chris Argyris, "The Individual and the Organization: Some Problems of Mutual Adjustment," Administrative Science Quarterly, Vol. 2 (June, 1957), pp. 1-24.

⁴² See Leonard P. Ullmann, Institution and Outcome (Oxford: Pergamon Press, 1967), p. 125.

Thus evaluators see it as essential to supplement their technical knowledge and relationship with the director with good interpersonal relationships with the clinical staff.⁴³

One evaluator described himself as a "marginal man" in the organization. Generally, both evaluators and other staff see an important difference between clinicians who "produced" (e. g. in the form of therapy) something immediately of value for the organization and researchers whose product and worth is less easily defined or measured. An awareness concerning this point of difference is plainly evident in the following comments of a director and evaluator:

(Director) Research takes some time before production comes forth and this isn't true of clinicians. When we hire one usually the first day or two they have seen a couple of patients and have produced something.

(Evaluator) I am a member of the planning staff [of the entire organization] and as director of research and evaluation I am supposed to be there at the meeting. I want to be there but I won't go until I have something to take with me. I look at [name of clinician] who is outpatient director and he provides a service, sits down and talks, writes out an admission form, a progress report, and he has done something. . . . I have been attempting to develop a credibility, doing small kinds of projects for the outpatient people. . . .

Another evaluator (at a different organization) concurs with the need

⁴³As was discussed in Chapter III, there was no example of the network of informal relations directly blocking the efforts of the evaluator. Yet the informal system had a very important effect in that the evaluator attempted to anticipate and avoid any potential anxiety and resistance.

to "produce something":

(Evaluator) I think my initial way of doing something is to get at it quick, provide something to somebody fast so that the people could see that we could produce something that they could grab hold of. . . . I think the key to the job is being productive and visible fast.

It was suggested in the last chapter that the evaluator's performance of "non-evaluative" duties is to a certain extent the result of the necessity to deal with survival needs first and also the tendency of programmed activities to drive out "non-programmed" activities. However, another reason is that performing "service functions" for the directors and clinicians help evaluators to establish personal relationships with other staff members. It is also a means by which evaluators can provide a "concrete" service quickly in order to justify the resources spent on their salaries. The irony of the situation is that evaluators are being responsive to the needs of the clinicians rather than the other way around.

While this service approach is likely to enable the evaluators to establish good relationships with the clinicians, evaluators tend to get "locked into" a role of doing service and descriptive types of activities. They find it difficult to escape from these types of activities and to carry out more formal and analytical kinds, like research and evaluation:

(Evaluator) What happened was that when I started doing that, I got myself overloaded with a lot of descriptive stuff, and

didn't get into any actual evaluation for several months because of it. As a result, a lot of people kept asking me--they got the impression that that [descriptive activities] is what I am supposed to do--so they kept asking me to do all of this descriptive stuff such as compiling the ages of people in programs. Not that it is not interesting and important but it doesn't tell you all that much about how your programs are doing. . . . I was using that initially to provide them public relations and a service but I ended up constantly having to provide them a service.

On the other hand, an evaluator who uses a more "hard sell" approach received a negative reaction from the clinical staff and the director of the organization:

(Director) [Name of the evaluator] does nothing to court them either. . . . ____ does give them negative feedback but he does it in a way that makes it look very defensive on his part: "I couldn't get the cooperation of the therapist here and that is why this is an invalid program," and I say to ____, "What did you do to get the cooperation?" and it turns out that on one project, the therapist didn't even know that he was doing the project and yet he [the evaluator] labeled him [therapist] uncooperative.

The great difficulty of performing the role of the evaluator is apparent from the statements above. He must prove his worth to the organization and develop good relationships with clinicians. In order to do this, he has to compromise his role from that of being a "pure" evaluator.

The Authority of External Evaluators

Authority of position

The nature of the authority exercised by the outside evaluators to achieve responsiveness to their values is quite different. To achieve their demands, they relied basically on their formal authority

in the form of control over funds. These outside agencies and boards do not feel it necessary to develop relationships with the clinical staff but are able to say, in effect, "Carry out this evaluation if you want to receive money from us."

The centers have money coming from several sources including local, state and national governments.⁴⁴ Despite these multiple sources of funding they are not in the position to decline a source of funding. Outsiders' use of this formal authority generated some antagonism and resistance. The personnel of the centers viewed these outside requirements for accountability as being mechanisms of control only. They spend a great deal of time filling out forms from which they do not receive useful feedback. A program director describes his reaction to one example of data collection by the State:

(Supervisory Clinician) We were told by those in charge of dispensing the money that we had to keep a log of the time we spent with a certain type of patient for a certain month of the year. We wanted our money and so we went after it. Now we are told that we have to do that again. Now we probably want our money and we probably will go after it.

At a meeting attended by state officials, a director of a local organization told these officials that his Center was going to evaluate

⁴⁴The fact that organizations receive multiple sources of funding tends to make the job of internal evaluators more difficult. See, Lee Yudin and Stephen Ring, "The Impact on Research and Evaluation," American Journal of Orthopsychiatry, Vol. 41 (January, 1971), pp. 149-157.

the "cost of providing the information" (which was required by the State in order for the organization to receive funding) to the state agency. Another supervisory clinician saw the demands made by NIMH for evaluation and accountability as an attempt to destroy the mental health organizations:

(Supervisory Clinician) The worst possible source for the development of evaluation is Casper Weinberger.⁴⁵ We know Casper's game from California. He sets up these ponderous so-called evaluation techniques. He never says that he is going to cut off any programs but he just says, "Just fill out the following forms. . . ." And then he gets you going. . . .

In short, the sole reliance on formal authority by outside evaluators tends to provoke reaction and resistance.⁴⁶

Authority of competence

There is strong doubt among the personnel of the organizations that the local communities and particularly the local boards possess the knowledge to evaluate the quality of services provided by the mental health centers:

(Director #1) The quality of service has not been looked at by the community. I can't think of the community as being quality-oriented. They talk about whether or not services are being provided but not necessarily about the quality.

⁴⁵Casper Weinberger is the present head of the Department of Health, Education, and Welfare (HEW).

⁴⁶Social psychology has been used to handle reactions against the use of formal authority in the field of personnel administration. See Jacobo A. Varela, Psychological Solutions to Social Problems (New York: Academic Press, 1971), p. 123.

(Director #2) The district board would have no capability of carrying out an evaluation of the Center. The only thing I can think of would be for them to ask the Center: "Well, what are you doing?" But, for them to evaluate themselves all of the programs, I couldn't imagine them doing it.

(Director #3) They [the district board] never made any criticism of programs or services. Oh, they were disturbed by the fact that emergency services weren't being provided, but basically. . . . There has been nothing generated by the board of a critical nature of the programs and services.

The boards are more interested in financial forms of accountability and responsibility than in the qualitative aspects of services. The personnel of the organizations usually recognize this interest in financial accountability to be a valid and important area for the boards to "evaluate." In the area of monetary concerns, the boards are on a more equal basis of understanding with the center personnel than they are in the area of determining the quality of programs.

Sometimes the district boards are seen as becoming overly focused on not only problems of money but "petty" things such as catching personnel of the mental health organization shopping during work hours:

(Psychiatrist) Take, for example, the case of [name of member of the staff of the mental health organization]. She spends ten to twelve hours a day working but then she is caught downtown shopping during the day by a member of the district board.

(Business Manager) We are always on the defensive. If they think they can do better with someone else. . . . Some of the questions they ask, a kid in grade school wouldn't ask.

(Director) They use the budget to maintain control.

(Business Manager) We want to be members of what is considered to be a good organization.

(Director) It would be nice if the board would focus on programs. . . .

The emphasis by the district boards and agencies on fiscal kinds of accountability measures led one director to declare at a meeting attended by the author that accountability and evaluation (qualitative) were completely different:⁴⁷

(Director) I think that there has been an intermingling between evaluation and accountability in this discussion. I don't think they are the same thing. Let's move over to evaluation and leave accountability to the fiscal officers. It's really up to your business administrators. I think evaluation and accountability are completely different.

Others took issue with this director by arguing that there are more kinds of accountability than simply fiscal accountability.⁴⁸

The state and national agencies are seen as being more knowledgeable about quality of service than the local boards. Yet, these agencies simply do not have the time nor, perhaps, the motivation to spend very much time evaluating one organization. Consequently,

⁴⁷This statement occurred at a meeting with various other directors, evaluators, and officials present. Most directors did tend to associate accountability with dollars and cents issues and also quantitative indices. However, in a later interview, this same director admitted that there were other forms of accountability than simply "fiscal accountability."

⁴⁸The plurality of interpretations of the meaning of accountability has been noted by others. See, e.g., Kaplan and Roman, The Organization and Delivery, pp. 299-300.

they tend to rely on two major forms of data to evaluate these organizations: (1) selected quantitative criteria such as cost per encounter, reduction in mental hospital loads, and so forth, and (2) on-site visits by representatives from the agencies.

Most personnel of the organizations reject the idea that their organization can be adequately evaluated by selected quantitative data:

(Director) I think that the larger the unit you go to, the more difficult it becomes to make valid comparisons. I think it would be difficult enough to make comparisons within a single Center, but when you extrapolate out statewide and try to use a single system to make comparisons among all of the centers and clinics in the State of Florida, it may be conceivably possible but I would hate to be on the other end. . . . The anxiety is always there that somebody may very well hold it up and say, "That's it." That is the risk in setting up any kind of data system--that some. . . will think that that item of data is the only thing that should be used in the determination. . . .

"While some members of the organization feel that the on-site visits are among the more useful forms of evaluation because of the personal contact they have with the outside evaluators, others doubt the utility of this form of evaluation also:

(Director #1) I am even more skeptical of outside evaluations. The most helpful to me have been on-site visits by NIMH and the State. . . .

(Supervisory Clinician) NIMH comes down here. . . . That is a disconcerting thing because we don't have the time to explain to them and so forth. It is funny. You don't get shaken by it but you know that they are not understanding. . . but it never seems to get through because they have already reached their conclusions about what they think you should be doing that you are not doing. They don't even know whether you can do them or not. Everyone is nice. We just never deal with one another. We are just nice.

(Director #2) When NIMH comes down once or twice a year to consult, you get a review, but it is a very, very gross one. It simply sees whether or not you are doing what you said you were going to be doing in the grant.

(Director #3) So, up to the present time, the NIMH type of visit has not been that useful to us. They have forced us to do certain things, like install the time-clocks, which the professionals resent. They think that they should be trusted.

Without exception, all clinicians and directors interviewed prefer inside evaluations to those done by outsiders. In large part, this is undoubtedly due to the fact that they perceive the former to be less threatening. Another factor is that inside evaluations are seen as being more capable of feeding back something of value to the organization because they understand its complexity and decision making system:

(Supervisory Clinician) Results can be read within terms of their total knowledge. Straight numbers often don't have much meaning. . . . And we just have more confidence in somebody we know better than someone else.

(Director #1) If you want to do any in-depth kind of thing, you have to know what is going on. Unless you want to send in any evaluation team to stay here for three or four months and work out an evaluation--then an outsider might be able to do it.

(Director #2) I am not interested in the people coming in for a one-shot evaluation--that kind of a thing is not helpful. Having a research staff on a long term basis could assist--that is of interest to me.

(Evaluator) This clinic is so complex that it takes a very long time to learn about it--which you really should do to set up good evaluation programs.

Summary of Authority

The types of authority exercised by inside and outside evaluators are quite different. Inside evaluators rely on respect for their knowledge and relationships with the director and clinical staff in order to develop their evaluation programs. In developing their relationships with the clinical staff, inside evaluators tend to avoid the more analytical and critical types of evaluation.

Outside evaluators rely upon their formal authority and, especially, their control over the purse strings of the organizations to achieve the responsiveness which they desire. As a consequence, they do not have to "waste time" developing "authority of person," but the exclusive use of formal authority tends to provoke reaction and resistance from those being evaluated. The authority of competence of outsiders is perceived to be limited either because of their lack of substantive knowledge concerning mental health services or lack of time and adequate methods to truly understand the operations of the local organizations.

Information

Evaluation does not always have its intended impact. It is important for evaluators to possess sufficient information to judge whether the organizations are being responsive to their values and priorities as a result of the evaluations. There are at least two

major kinds of problems in utilizing the information derived from evaluation: (1) the clarity and meaningfulness of the data, and (2) the accuracy of the information.

Inside Evaluations

It has already been described how inside evaluation is generally introduced in such a non-threatening way that there are no specific penalties or rewards attached to compliance with it. There are also no systematic plans to use any recommendations or implications that could be drawn from the evaluations in making decisions in the organization. Thus, there are not great expectations concerning the anticipated impact of these inside evaluations.

However, through their informal contacts with the clinical staff and their personal observation of the operations of the organizations, perceptive inside evaluators are able to get substantial feedback concerning the reaction of other staff members to their evaluation.⁴⁹ Thus, they usually have at least a rough estimate of the accuracy of the data and its meaningfulness within the context of the particular constraints faced by the individual organization.

⁴⁹The personality of the evaluator seemed to be an important factor in determining the amount of information he received from the clinicians. While the sample of evaluators is quite small, certain evaluators seemed to be quite gregarious and actively sought out feedback from the clinical staff. Others were much more reserved and appeared to have less contact with the clinicians and less feedback as a result.

Outside Evaluations

Much of the data provided to outsiders is seen as being of doubtful value in helping them to determine whether the organizations are being responsive to their wishes. One district board requested a "program budget" from a Center as a means of gaining insight into the operations of the Center and how well it was performing. The evaluator within this organization questioned whether the board could adequately interpret the data from this budget. He perceives that the director of the Center is attempting to "snow" the board with the data provided to them:

(Evaluator) Unfortunately, I think that he would like to manipulate evaluation to meet his needs of controlling the board. . . . I am afraid that he perceived in this program budget. . . his real thrust with that was not to get the information because he [director] hasn't used it. His thrust was to manipulate the board with that data. The latest thing he has asked me to do is to come up with beautiful charts which show the highest incidence of certain types of social indicators--things that will impress the board. I think that, again, program evaluation is a camouflage or a diversion for the board--to keep the board interested, busy, and out of his hair.

The director of another Center is frank about his doubts of the board's ability to understand complex data:

(Director) The best way is to turn out statistics. They [the district board] generally accept that. For example, how many people are treated--that is the biggest thing. But to get down any further--I just don't think it would be understood.

It is not just the lack of competence which prevents outside boards and agencies from being able to use information from

evaluations. All of the data obtained have some degree of ambiguity.

A director of a Center which was admittedly very high on the cost per patient figures is quite honest in describing how he would justify this high cost to the district board:

(Director) I am going to go in there with some fancy foot-work and razzamatazz, and say, "Hey, I have sixty-seven inpatient beds, and this cost data means less. . . . Look at all of our positive points. . . . Well, sure [name of another clinic] is doing it for one hundred times less money than we are, but they only have outpatient services. . . . And [name of another mental health center in the same city] have fewer inpatient beds, and they don't have this, and we have this, and we have to do this and that. . . ." So when it comes down to this dollars and cents thing, they are going to be confused anyway. So ultimately it will go back to--have we impressed them with what we are doing? And if we have done that, we are going to survive.

As far as the state and national agencies are concerned, a great problem is the extent to which their "evaluations" lead to goal displacement. One director points out that decreases in hospitalization rates can be achieved in several ways:

(Director) I am concerned with the pre-existing conclusions. When lack of hospitalization is considered as a criteria of success, you can tell people if they ever show up in the county again you are going to put them in the hospital forever.

Or the problem of high inpatient figures can be "solved" by drugs:

(Director) If you keep a patient quiet with 2200 milligrams of thorazine and half of them die, and you didn't have to admit any of them, you have gotten great results. . . . Or, if they don't die, they are likely to be zombie-like. . . .

The accuracy of the data collected in evaluations is questionable for several reasons. Sometimes the organizations simply do not

possess the information requested, as in the following case:

(Director) I had a hard time filling out the financial report because our hospital does not break down the Center as a separate entity. So when I get together with the financial director for the hospital and say, "Well, they want to know what our expenses are for this fiscal year?"--he doesn't know. I mean with a 100 percent certainty, he does not know what it is.

The staff members in one organization were sharply criticizing the paperwork required by outside agencies. However, one staff member told how she was able to fill out a complex form in a few minutes by giving short and minimal replies to questions.⁵⁰ The director of an organization strongly committed to indirect services told the author how he "handled" forms which emphasize large numbers of direct encounters as a criterion of "goodness." He said he had developed the concept of "non-case" encounters which he included in the figures used for calculating the cost per encounter.⁵¹

⁵⁰ Another member of this organization who received the forms sent by this staff member confirmed her contention about the little time spent on the forms, but said that, as a result, it was impossible to acquire needed data about the patient from the form.

⁵¹ However, this director admitted that the latest form of accountability developed by NIMH virtually excluded indirect services. He noted that it was almost "as if they want you to fail." This points out the fact that the agencies were able to be quite critical of individual mental health centers despite the doubts expressed on this point by private psychiatrists. The reason for their detachment from the cause of the local centers is the fact that the survival of the state and national agencies is becoming more and more tied to a research and evaluation role. NIMH is encouraging community evaluation of the mental health centers and offering consultation to the community groups in order to help them carry out such evaluations. See Susan Salasin, "Conversational Contact with Bertram S. Brown," Evaluation, Vol. 1, No. 2 (1973), p. 17.

Thus, lack of accuracy in the information can result from lack of availability of the information, inadequate attention to the forms by staff members, and "interpretation" of the data which deviates from its original interpretation by outside agencies.

Another form of inaccuracy is the result of deliberate cheating. Indeed, many of the persons within the organization freely admit that cheating occurs. Unlike the cheating described by Cohen,⁵² much of the cheating on forms is seen as contributing to the accomplishment of organizational goals by cutting down on what the staff regard as unreasonable demands made by outside agencies.⁵³ A director of one organization describes how one of the workers on his staff became skeptical of the amount of data required by the state agency:

(Director) First she fabricated the data. Then she stopped sending it in altogether. She said, "Nobody can possibly want this." It took the State nine months to find out what had happened.

⁵²Harry Cohen has done one of the few systematic studies of this widespread and important behavior pattern in organizations--cheating. See Harry Cohen, The Demonic of Bureaucracy (Ames: Iowa State University Press, 1965).

⁵³Thus, one clinician described to the author how it was frustrating for a client to come in with a desire to discuss his problems immediately and then to be faced with answering questions on an intake form required by the State. This clinician attempted to avoid "putting off" the patient by letting him discuss his problems and obtaining as much information required by the intake form as possible from this discussion.

A clinician at one Center directly told the director and evaluator in the organization that it "was easy to make it look like you are doing a lot" with the activity sheets used by organizations.

Another clinician told a state official involved in introducing evaluation that "if we have to put down numbers, we are going to cheat."

Summary of Information

Merely carrying out an evaluation by no means guarantees that the staff will actually be responsive to the values which the evaluator wishes to emphasize. Moreover, the data obtained by the evaluation will not necessarily be clear or accurate.

Inside evaluators begin with much lower expectations than outside evaluators as to what their evaluations are likely to accomplish. However, their informal contacts with the staff and ability to observe the behavior of the organizational members give them a rough idea of the accuracy and meaningfulness of the data obtained.

Outside evaluators are likely to have greater difficulty in interpreting the meaningfulness of the data and its degree of accuracy. They have to contend with ambiguity of interpretation, information overload, and lack of accuracy in the data. Moreover, the staff whom these outsiders are evaluating are not apologetic about the cheating and "curt" attention given to demands for evaluation and

accountability.⁵⁴

Conclusions

The purpose of this chapter was to examine the relationship between evaluation, accountability, and responsibility. In particular, the factors which are important in determining the degree of responsiveness which an evaluator can achieve from those whom he evaluates were analyzed. To aid in this analysis, comparisons between insider and outsider evaluations were utilized. Four problem areas are seen as being important in determining the amount of responsiveness to evaluators and evaluation: (1) the kinds of values held by the evaluators and persons being evaluated, (2) the motivation behind the evaluation--its nature and strength, (3) the kinds of authority possessed and exercised by the evaluators and the reaction of those being evaluated to them, and (4) the extent to which the evaluators possess the information necessary to discover whether the evaluation is achieving its intended impact.

⁵⁴The attitudes of these staff members bear striking resemblance to the attitudes of the personnel in "OPA." Victor Thompson writes, "At the end of rationing, some branch personnel thought that they spent so much time explaining to their superiors what they did. . . that they did not have much time left to do anything." He also notes that "the relationship tended to develop into one where the working people seemed to be mischievous children who had to be controlled rather than experts who were actually responsible for the successful rationing of the commodity." See Victor A. Thompson, The Regulatory Process in OPA Rationing (New York: King's Crown Press, 1950), p. 231.

It was found that the degree of congruence between the values of the evaluators and those being evaluated is important in determining the need for evaluation. Evaluation for the purposes of accountability and responsibility is likely to be less necessary when the persons being evaluated share the values of the evaluators. When the two value systems diverge, there is likely to be reaction and resistance to the evaluation. Another problem is that the values and goals of persons, programs, agencies and mental health organizations in general are not very clear once one gets beyond gross generalities. In such a situation there is a great chance for goal displacement in which the staffs of the organizations overemphasize goals included in the forms required by funding agencies. Indeed, in the absence of clearly stated and operational goals, the "forms of accountability" are seen by the personnel of the organizations as the values desired by the management (for internal evaluations) or outside agencies and district boards (for external evaluations).

There is evidence that persons outside of the organization tend to emphasize monetary and quantitative indices while internal evaluations tend to be more concerned with problems of the quality of service being provided. When persons being evaluated sharply disagree with the values emphasized by the evaluation and forms of accountability, they may see evaluation, accountability, and responsibility as actually being "negative values" and actively resist them.

The motivation to evaluate is the second element in our analysis of the problem of achieving responsibility. Outside agencies and boards tend to see evaluation as having the purpose of "catching the cheaters" and achieving the accountability and responsiveness which they desire from the organizations being evaluated. Inside evaluators and other staff in these organizations prefer to use evaluation as a means of providing internal feedback rather than using it primarily for the purpose of forcing responsiveness to community and other "outsider" values. Thus, inside evaluations tend to be less "critical" in the sense that they are not usually intended to prove whether or not the programs are worth continuing because this is assumed to be the case.

Nevertheless, it was found that there are several factors which do facilitate highly critical types of internal evaluations. However, the most critical forms of evaluation are not the formalized evaluations, which are expected to be highly positive in nature, but the more informal and subjective types of judgments that constantly take place in organizations. Professionalism does not prove to be a major obstacle to the implementation of formal evaluation and probably contributes in part to the impetus for critical internal evaluation. Generally, highly critical attitudes are correlated with various factors which made the evaluator feel apart or "removed from" the persons, programs, and organizations which he is evaluating. This

detachment can result from being in a different program or level of hierarchy in the organization than those being evaluated. It can also result from differences in values from those being evaluated or career ambitions which would take the evaluator away from the organization and those being evaluated.

In order to carry out an evaluation, an evaluator must possess some kind of authority. Three major types are singled out: (1) authority of position, (2) authority of person, and (3) authority of competence. Authority of person is subdivided into three components of the evaluator's relationships and duties in the organization: his relationship to the director and clinical staff, and his performance of non-evaluative tasks. Questionnaire data indicates that technical competence is regarded as the single most important factor, and formal power as being the least important by the persons sampled.

However, interviews and participant observation data indicate that the evaluator's role is a particularly precarious one. He needs to develop all potential sources of authority. His relationships with the director and clinical staff are also critical factors in determining whether he is effective. Ironically, the evaluator's attempts to develop these relationships, especially those with the clinical staff, tend to deflect him from his original task of evaluation towards mere data gathering and description.

Outside evaluators rely almost totally on their formal authority or control over the purse strings. The use of formal authority exclusively tends to evoke reaction and resistance from organizational members. Outsiders are not recognized as having authority of competence to the same extent as inside evaluators in these organizations. The district boards lack knowledge concerning the quality of mental health programs and methods. Agency members are seen as having a greater degree of knowledge of mental health programs but as lacking the time and motivation to learn about the particular context and constraints of specific mental health organizations.

The final factor in determining the amount of responsiveness which an evaluator can achieve is the amount of knowledge or information concerning whether the forms of evaluation and accountability actually have their intended impact. The major problem of the inside evaluators is that they have designed their evaluations mainly to provide feedback without any systematic check to find out whether evaluation has any impact. However, they are usually able to secure substantial feedback concerning the effect of evaluation through observation of the organization's activities and their relationship with the clinical staff of the organization.

Outsiders rely mainly on data provided to them by people within the organizations and on-site visits. The data is often inaccurate because of the fact that it is perfunctorily collected or because

accurate estimates for the figures are not actually available. Also, outsiders are seen as frequently not able to digest or interpret these figures meaningfully. Finally, there are significant chances for deliberate misrepresentation of the data by the staff of the organizations. Cheating does not appear to be done so much for personal gain or advantage of the organization as it is for limiting the amount of time spent on accountability and evaluation.

More briefly, the arguments above may be summarized in the following form:

(1) The degree of responsiveness which an evaluator achieves to the values which he wishes to emphasize is a positive function of: (a) the amount of authority he possesses, (b) the degree of his motivation to achieve this responsiveness, and (c) the extent to which he possesses accurate information concerning the actual impact of the evaluation.

(2) The degree of responsiveness which an evaluator achieves to the values which he desires to emphasize is a negative function of: (a) the difference between his own values and the values of those whom he is evaluating, (b) the degree of goal displacement which occurs, and (c) the degree of reaction against his use of authority.

Comparisons were utilized between inside and outside evaluators concerning the factors which facilitated or hindered them from achieving responsiveness to their values. It was found (not unsurprisingly) that each has its advantages in achieving this responsiveness. Outsiders have greater formal authority and can afford to be much more critical in the nature of their evaluations. Insiders have the capacity to gather more accurate information

concerning whether the desired impact has actually been achieved. They also evoke less reaction from the staff. Organizations generally do not willingly provide information to outsiders that reflects negatively on them. Internal evaluations may or may not provide the functional equivalent of outside evaluations. Whether they do or not depends greatly on the degree of congruence between the values and priorities which inside and outside evaluators are interested in emphasizing.

Accountability and responsibility are strongly tied in with value judgments. Moreover, they are generally seen as being positive values by the public and people within the organizations. However, they are achieved at a cost of time spent collecting the information, and also the anxiety and reaction aroused as a result of the motivation which the staff perceived behind them--a lack of trust.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The major aim of this study has been to analyze the role that formal, scientific evaluation has played in the mental health organizations. Formal evaluation was defined as "the process of measuring goals, however defined, through the use of the tools of science." In particular, the focus of this study was the extent to which organizations can critically evaluate their own performance. Three dimensions of formal evaluation were singled out in order to distinguish between token and critical evaluations: scope, focus, and substance.

The sample of organizations in this study included fourteen mental health organizations in the State of Florida. Three major kinds of data were used: (a) questionnaires to certain clinicians, directors, and evaluators in these fourteen mental health organizations, (b) interviews with individuals from these same three groups, and (c) approximately five months of participant observation in one organization.

The problem of what role evaluation has played in this group of organizations was seen as being related to four areas of organizational and public administration research: (1) the relationship

between the natural and artificial systems of an organization, (2) the technology employed by organizations, (3) the problem of achieving accountability and responsibility in public organizations, and (4) the relationship between survival and goal-attainment models of organizations. Insights from the literature of organizational theory and public administration concerning these problem areas were employed in our analysis of the role of evaluation.

In Chapter II, the technology and impact of formal evaluation in these fourteen organizations were examined with respect to the dimensions of scope, focus, and substance. The major finding was that formal evaluation had little visible impact on the operations of the organizations in which it was introduced. At the time of this study, evaluation was being used internally to some degree for the purpose of providing feedback to the personnel of the organizations concerning the reactions of the clientele to the services which they received.

In Chapter III, attitudes toward formal evaluation were analyzed. Questionnaire data revealed a favorable orientation toward formal evaluation for general purposes among the clinicians, directors, and evaluators surveyed. Not surprisingly, clinicians favored more generalized uses of evaluation to more specific and potentially threatening uses. Less expectedly, the evaluators preferred the same types of non-threatening uses of evaluation. They apparently

had encountered little direct opposition because they favored such non-threatening uses of evaluation. Thus, the most important effect of the natural system was seen as being indirect because the evaluators had anticipated the reactions of others in the organization to threatening evaluations. Two inductive hypotheses were suggested concerning attitudes towards evaluations:

(1) Persons being evaluated will favor those evaluations which minimize potential threats to themselves and maximize potential benefits.

(2) The degree to which evaluators favor non-threatening evaluations will be a positive function of the amount of resistance anticipated by the evaluator and a negative function of the amount of authority possessed by the evaluator.

The attitudes of clinicians and directors in the organizations under study toward the technology of evaluation were ambivalent. They were willing to experiment with formal evaluation but retained substantial doubt concerning its validity and meaningfulness for making specific decisions or comparisons. Clinicians and directors generally rejected attempts to judge the worth of their activities and programs that ignored the particular constraints which they faced. The preference for program evaluation was significant in view of the fact that the most prevalent forms of evaluation employed by these organizations were actually gauged to measuring individual performances. Thus, the kinds of evaluations favored were not controlled by the kinds of techniques available.

The actual decision making process of these organizations was studied with respect to evaluation. It was found that evaluative judgments were constantly being made. However, these judgments were mainly of an informal and highly subjective nature. They were based on the eclectic combination of personal values of decision makers and whatever sources of information that were available to them. The nature of the decision making process of these organizations made it appear that formal evaluation would play a marginal (though potentially significant) role in this process.

All evaluations, formal or informal, emphasize certain values. The implementation of formal evaluation is likely to make the values behind the evaluation more apparent. Where values held by organizational members differ substantially, formal evaluation can potentially increase conflict.

The reasons why many of these organizations had decided to invest in formal evaluation was studied. It was noted that many organizations were hesitant to invest in formal evaluation and evaluators because of the actual or potential costs involved. However, those organizations which did invest in evaluation expect the following actual or potential benefits to result from investment in it:

- (1) giving the organization a headstart on future evaluation that is likely to be required, (2) providing the organization with a method of justifying the public funds being spent in support of it, (3) yielding

dollars and cents benefits in the form of grants that were tied directly or indirectly to the performance of formal evaluation, and (4) the contribution of the evaluation staff to the performance of non-evaluative tasks crucial or important to the survival of the organization. A hypothesis was developed to explain the relatively great interest of mental health organizations in undertaking formal evaluation:

(3) The degree to which an organization attempts to anticipate its environment is a function of the interaction between the degree of concern of the organizational members for its survival and the extent to which organizational members are capable of scanning the environment.

The reasons for the source of variation in the extent to which these organizations invested in formal evaluation were sought. It was found that by far the most important variable was the attitude of the director of the organization. Directors weighed the advantages and disadvantages associated with undertaking formal evaluation for the survival of the organization. They also considered the merits of evaluation with respect to their personal values and ambitions.

There was an apparent discrepancy between the preferences expressed by the clinicians on the questionnaire concerning the functions of evaluation and the purposes actually behind the impetus to undertake formal evaluation. It was also noted how evaluators became more involved in "non-evaluative" tasks than in their internal, formal evaluation tasks. Two hypotheses were developed

to explain the above occurrences:

(4) Evaluation activities associated with organizational survival will displace other activities which are not directly related to organizational survival.

(5) The degree of displacement of evaluation from goal-oriented objectives to survival objectives is a function of the degree of concern for organizational survival of organizational members and the number of demands made by outside agencies on these organizations.

In Chapter V, the relationship between evaluation and the concepts of accountability and responsibility was analyzed. A comparison was utilized between inside and outside evaluations in order to study the factors important to an evaluator in the achievement of responsiveness to his evaluation. Four major concepts were seen as being the key to understanding the degree of responsiveness achieved: values, motivation, authority, and information. Two hypotheses were developed which summarized the relationships among these factors (and subcomponents of them):

(6) The degree of responsiveness which an evaluator achieves to the values which he wishes to emphasize is a positive function of: (a) the amount of authority he possesses, (b) the degree of his motivation to achieve this responsiveness, and (c) the extent to which he possesses accurate information concerning the actual impact of the evaluation.

(7) The degree of responsiveness which an evaluator achieves to the values which he desires to emphasize is a negative function of: (a) the difference between his own values and the values of those whom he is evaluating, (b) the degree of goal displacement which occurs, and (c) the degree of reaction against his use of authority.

At the very beginning of this study, it was noted that the

original inspiration for this study was an article by Aaron Wildavsky which suggested that organizations may be incapable of evaluating themselves.¹ In hypothetical form, Wildavsky's hypothesis was stated as follows:

Due to survival needs, organizations cannot critically evaluate themselves, and any evaluations which they do implement will tend to be narrow, technique-oriented, and symbolic.

It was argued in Chapter IV that the major reason behind the movement towards formal evaluation was the organization's struggle for survival. The apparent contradiction of this conclusion with the Wildavsky hypothesis is explained by the nature of the formal evaluations undertaken by these organizations. They had introduced evaluation in such a non-threatening manner that there was little evidence of resulting substantive change. Evaluation was expected to contribute to the survival of the organizations which invested in it. Based upon the way that evaluation and evaluators were displaced toward survival purposes and activities, it does appear that organizations cannot closely approach what Wildavsky calls a perfectly self-evaluating organization.

Nevertheless, critical judgments and evaluation did take place within the organizations. Many of the persons in these organizations

¹Aaron Wildavsky, "The Self-Evaluating Organization," Public Administration Review, Vol. 32 (November/December, 1972), pp. 509-520.

did appear to be quite interested in receiving feedback from the formal evaluation. The increment of knowledge added by evaluation may be important for directors and clinicians in making some decisions. Moreover, there are several factors which enable individuals to critically examine the worth of the services provided by the organization, such as values and ambitions brought in from outside the organization.

Perhaps an even more important limitation than the internal ones upon the possibility of truly critical self-evaluation by organizations is the nature of these organization's environments. Outsiders assumed that the organizations would make themselves look as good as possible. Members of these organizations perceived this expectation and generally attempted to fulfill it by presenting information to outsiders which reflected favorably on their organizations. The extent to which critical, internal evaluation (formal or informal) provides the functional equivalent of outside evaluation depends upon the degree of congruence between the values and priorities of insiders and outsiders.

Based upon the analysis above, there would appear to be two fairly effective ways to facilitate critical organizational self-evaluation. One way is by rewarding individuals within the organizations (and organizations as a whole) for reporting accurate rather than

merely favorable information.² A second way is to encourage the growth of value systems and attachments which are more cosmopolitan, less local.³ However, it should be noted that increased ability of organizations to evaluate themselves is likely to have many costs, e. g., instability.

In summary, very few organizations, if any, are capable of fulfilling Wildavsky's model of a self-evaluation organization. However, organizations are open systems and absorb elements which do facilitate self-evaluation. However, evaluation appears to be one of the most difficult activities to carry out in organizations because of the tremendous anxiety and other costs associated with it. While internal evaluators appeared to be making very slow headway as far as accomplishing visible change is concerned, they appeared in a much more favorable light when compared to outside evaluators. The latter often appear to generate a negative effect upon the organizations that they evaluate.

Evaluation may or may not achieve the goals intended to be accomplished by it. It may or may not be worth the cost of the

²Wildavsky pointed out that trust is a condition of successful evaluation in Wildavsky, *ibid.*, pp. 519-520.

³For a recent attempt to encourage "cosmopolitan" attachments in organizations, see Ralph Nadar, Peter J. Petkas, and Kate Blackwell, eds., Whistle Blowing (New York: Grossman Publishers, 1972).

resources invested in it. In short, evaluation itself needs to be evaluated. Renos Dubos has summarized the position taken here quite well:

What is new is not necessarily good, and all changes, even those apparently most desirable, are always fraught with unpredictable consequences. The scientist must beware of having to admit, like Captain Ahab, in Melville's Moby Dick, "All my means are sane; my motives and objects mad."⁴

⁴Renos Dubos, Mirage of Health: Utopias, Progress, and Biological Change (New York: Harper and Row, 1959), pp. 227-228.

APPENDIX

The Questionnaire

Note: Evaluation below refers specifically to formal evaluation carried out by an evaluator and his staff (in a mental health organization).

1. Evaluation can and should be used to furnish feedback for the clinical staff.

_____ Strongly Agree

_____ Agree

_____ Undecided

_____ Disagree

_____ Strongly Disagree

(The identical series of five response categories is repeated after each item.)

2. Evaluation can and should be used to determine whether individual mental health programs are successful or not.
3. Evaluation can and should be used to determine whether or not the overall organization is performing well.
4. It is likely that evaluation will cost more than the information derived from it is worth.
5. Only the clinical staff involved in direct services can actually judge whether or not programs are successful.
6. Evaluation can and should be used to determine whether or not individual clinical staff members are performing their jobs well.

7. Evaluation should only be undertaken after the mental health organization has met the demands for resources by the direct services.
8. Evaluation can and should be used to provide accountability of the mental health organization to the community it serves.
9. Evaluation can and should be used to provide accountability of the clinical staff to the clientele of the mental health organization.
10. Evaluation is unlikely to add to our knowledge concerning the dynamics of mental health.
11. Evaluation can and should be used to determine who should be fired from their jobs.
12. Evaluation is likely to be used as a means of control over the staff.
13. Staff are likely to overemphasize the activities and goals measured by evaluation.
14. It is impossible to measure quantitatively the most important effects of mental health direct services.
15. Evaluation can and should be used to determine how much funding mental health organizations should receive.
16. Evaluation can and should be used to determine which service programs, if any, are performing poorly.
17. Evaluation is unlikely to produce information relevant to the people performing direct services.
18. Evaluation is currently neither valid nor reliable enough to be used to determine who should be promoted within the organization.
19. Evaluation is likely to increase the efficiency of the organization.
20. Evaluation can and should be used to determine the impact of the organization's programs on the community.
21. Evaluation is likely to improve the quality of administrative decision making in the organization.

22. Evaluation is neither valid nor reliable enough to be used to determine who is doing a good job.
23. Most of the information derived from evaluation is unlikely to be used in actual administrative decision making.
24. Evaluation is necessarily of lower priority than the direct delivery of services.
25. Professional clinical staff are capable of evaluating their own performance without the aid of a formal evaluation by an evaluator.
26. Evaluation is likely to be used to regulate the behavior of the clinical staff.
27. Community control over mental health services can and should be increased through the use of evaluation.
28. A higher percentage of the total budget (of the mental health organization) should be devoted to evaluation than is currently the case.

Please rank the following factors in what you regard to be their order of importance as obstacles to evaluation. Evaluation below refers specifically to formal evaluation carried out by an evaluator and his staff. (1 = the most important obstacle; 5 = the least important obstacle).

- _____ The lack of reliability and validity of the current evaluation techniques.
- _____ Anxiety on the part of the direct service staff as to how evaluation is to be used.
- _____ The belief of professionals that they should evaluate themselves and don't need formal evaluation by an evaluator.
- _____ The lack of skills necessary in the evaluation staff to carry out a valid and reliable evaluation.
- _____ The lack of resources of time, money, and staff for the researchers to carry out valid and reliable evaluations.

Please rank the following in what you regard to be their order of importance as functions of evaluation. Evaluation below refers specifically to formal evaluation carried out by an evaluator and his staff. (1 = the most important function; 9 = the least important function).

- _____ Feedback for the clinical staff.
- _____ Evaluation of the performance of individual staff members.
- _____ Evaluation of the quality of the programs of the mental health organization.
- _____ Provide accountability to the community.
- _____ Provide accountability to the clientele.
- _____ Increase the efficiency of the organization.
- _____ Provide justification for the funding of the mental health organization.
- _____ Determine the allocation of resources among the different service programs within the organization.
- _____ Provide the means to regulate the organizational members' behavior.

Please rank the following in what you regard to be their order of importance in enabling an evaluator to establish an effective evaluation program. (1 = the most important; 5 = the least important).

- _____ The evaluator's formal role and powers in the organization.
- _____ The evaluator's personal friendships and relationships with the clinical staff.
- _____ The respect of the clinical staff for the evaluator's technical skills and knowledge.
- _____ The evaluator's relationships with and support from the head of the mental health organization.
- _____ The evaluator's contributions to "non-evaluative" aspects of his job such as data collection, grant-writing, and administration.

Please check the category which most closely approximates your position in the organization. (If more than one is appropriate, then check each--giving the percentages of time devoted to each position.)

Director _____

Evaluator _____

Clinician _____

(Other) Specify _____

How long has an evaluation program been established in your organization? (If no evaluation program has been established, then please indicate this.)

How long has the present head of the evaluation staff been in his or her position?

Approximately how many full time employees are on the research and evaluation staff? (Fractions may be used to represent employees who devote less than full time to research and evaluation.)

Approximately what percentage of the budget of the total mental health organization is being devoted to evaluation?

Please classify (in approximate terms) the clientele of the mental health organization:

Upper and upper middle class _____%

Middle and lower middle class _____%

Welfare and poor _____%

Approximately what percentage of the catchment area of the mental health organization can be classified as urban? (Urban is defined here as a locality containing greater than 10,000 persons.)

Indicate which (if any) of the following programs are being evaluated in your organization. Cross out all programs that are not currently being offered and add (in the blank spaces provided) any additional programs that are being offered (whether or not they are being evaluated).

	<u>Is Being Evaluated</u>	<u>Is Not Being Evaluated</u>
Inpatient	_____	_____
Outpatient	_____	_____
Emergency	_____	_____
Partial	_____	_____
Consultation	_____	_____
Children	_____	_____
Rehabilitation	_____	_____
R and D	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Approximately what is the total number of persons employed by your mental health organization?

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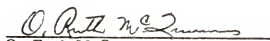
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Victor A. Thompson, Chairman
Professor of Political Science


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Department Chairman and Professor
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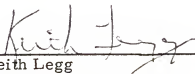
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